Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Mooncoin Residential Care Centre</th>
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<tr>
<td>Name of provider:</td>
<td>Mooncoin RCC Limited</td>
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<tr>
<td>Address of centre:</td>
<td>Polerone Road, Mooncoin, Kilkenny</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Date of inspection:</td>
<td>02 October 2019</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000254</td>
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<td>Fieldwork ID:</td>
<td>MON-0027842</td>
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About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Mooncoin Residential Care Centre is a purpose-built two-storey premises, which provides residential care for 78 people on the ground floor. The centre can accommodate both male and female residents, for long-term and short-term stays. The centre caters for residents of all dependencies, low, medium, high and maximum, and 24 hour nursing care is provided. In total there are 74 single and two twin bedrooms. All bedrooms have full en-suite facilities. Various communal areas are located around the centre which is surrounded by well-maintained grounds including a secure garden area and courtyard.

According to their statement of purpose, Mooncoin Residential Care Centre aims to provide the highest quality of residential care in a happy and homely atmosphere in which each resident feels cared for, comfortable and content. They aim to provide a home away from home, with a highly professional care service, where staff promote individuality and encourage residents to enjoy the company of friends and companions.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 78 |
How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (hereafter referred to as inspectors) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. **Capacity and capability of the service:**

   This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. **Quality and safety of the service:**

   This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:
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<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td>Wednesday 2 October 2019</td>
<td>08:30hrs to 15:30hrs</td>
<td>Catherine Rose Connolly Gargan</td>
<td>Lead</td>
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### What residents told us and what inspectors observed

Residents who spoke with the inspector expressed high levels of satisfaction with the care and service they received. Residents said they liked living in the centre, they felt safe and that there was a nice atmosphere in the centre.

Residents said staff always came when they needed them and they never had to wait for long periods for help. Some residents stated that they considered staff as members of their family. Some residents commented that they had 'fun' with the staff and that staff were always 'cheerful and chatty'.

Many residents commented on the food and said that it was 'lovely', 'plentiful' and that they always liked the food prepared for them. They confirmed that they were aware they could have alternatives to the menu if they wanted.

Some residents talked about their bedrooms and how they 'loved having a room to themselves with a toilet and shower'.

Residents knew they could make a complaint or raise issues as they wished and the person in charge and senior staff were always around to sort out any issues they had without delay.

One resident said that the garden was her favourite place and she thought it was 'beautiful' and confirmed that she was able to go out for fresh air and on bright sunny days as she wished.

Residents said their visitors were always made to feel welcome into the centre and that was important to them as they loved seeing their visitors coming in to be with them.

### Capacity and capability

This was an unannounced inspection and was triggered by solicited information received regarding the frequency with which residents were falling in the centre. The management team had identified falls as an area for improvement and while the numbers of residents falling had decreased. The inspector found that the incidence of falls and repeat falls remained high and further action was required to address this.

The provider and person in charge had already identified the high frequency of residents falling in the centre as an area that required improvement and had implemented several remedial strategies. However, the interventions implemented
were not effective in improving outcomes for residents. Evidence of a review of staffing resources to ensure vulnerable residents were appropriately supervised was not available. While intermittent supervision of residents was in place for all residents, arrangements were not in place to provide increased supervision of residents with assessed high risk of falling or residents who sustained recurrent falls.

Governance and management of the service required significant improvement to ensure residents' safety in the event of a fire in the centre and that management of residents' risk of falling was optimised. Assurances that sufficient staffing resources were provided to ensure residents could be evacuated to an area of safety and that fire and smoke would be effectively contained in the event of a fire in the centre were not available. The system in place to monitor the quality and safety of the service did not inform improvements needed. Key clinical parameters such as numbers of resident falls, residents' weights and infections among others were measured. Audits were also done on areas of the service including complaints, infection control and care planning and the outcomes were reviewed at the regular governance and management meetings. However, this information was not comprehensively analysed and action plans were not consistently developed to inform the necessary improvements regarding fire safety and management of residents' risk of falling.

Staff were facilitated to attend mandatory and professional development training. Staff were knowledgeable regarding residents' needs. Staff who spoke with the inspector said they were well supported by the person in charge and senior staff. The provider representative confirmed to the inspector that staff had completed An Garda Síochána (police) vetting before commencing working in the centre as per the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

### Regulation 15: Staffing

A staffing rota detailed the staff on duty and reflected the actual staff numbers and skill mix. The inspector was not assured that staff were appropriately allocated to supervise residents with assessed risk of falling or to meet the evacuation needs of residents in the event of an emergency. Two staff were on leave on the day of inspection and the person in charge told the inspector that she was unable to replace one health care assistant role. Arrangements were not in place to ensure vulnerable residents were appropriately supervised in the sitting room. The inspector observed on numerous occasions that there was no staff member present in the main sitting room. The system in place allowed for documented 30 minute checks of all residents by staff. However there was no increased frequency for residents at higher risk of falls. This arrangement did not provide assurances that vulnerable residents were appropriately supervised at all times.

There were 75 residents in the centre and three residents in hospital on the day of inspection. All residents’ accommodation was on ground floor level. The staff duty
roster referenced that there were three staff nurses on duty from 08:00 to 22:00hrs and two staff nurses from 22:00 to 08:00hrs. There were 13 care assistants on duty from 08:00 to 14:00hrs, eight care assistants on duty from 14:00hrs to 20:00hrs and four care assistants from 20:00 to 08:00hrs. However, as discussed under regulation 28: the records of simulated emergency evacuation drills did not provide assurances that there were sufficient staff on duty during the day or night to ensure timely horizontal evacuation of residents in the event of a fire in the centre.

Judgment: Not compliant

### Regulation 16: Training and staff development

Staff were facilitated to attend mandatory training. Staff who spoke with the inspector confirmed that they had attended training in safeguarding residents from abuse and fire safety. Staff were facilitated to attend professional development training informed by the needs of residents in the centre.

Annual appraisals were completed by the person in charge with staff. There were arrangements in place to ensure staff were supervised in accordance with their roles.

Judgment: Compliant

### Regulation 21: Records

The inspector examined a sample of staff files and they contained required information as outlined in schedule 2 of the regulations including a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

A record of restrictive equipment used in the centre was appropriately maintained.

A nursing record was maintained regarding each residents' health, wellbeing and treatments. These records were completed twice every 24 hours.

Records of emergency evacuation drills were maintained and included details of areas needing improvement and the actions taken.

All other records required under Schedules 1, 2, 3 and 4 of the Regulations were maintained.

Judgment: Compliant
The centre's management structure was clear and their roles and responsibilities were clearly defined. The management team met on a regular basis. Meetings were minuted and structured by means of a standing agenda that ensured all aspects of the service were reviewed at this forum. The governance and management of the centre required significant improvement to ensure that the service provided was safe, appropriate, consistent and effectively monitored regarding fire safety and supervision of residents in line with the centre’s statement of purpose.

While the results of audits were a standing agenda item reviewed at the governance and management meetings, any resulting actions taken including a review of staffing resources provided were not described. Key clinical parameters were measured to ensure the service was effective and outcomes of care were optimised for residents. Audits of some areas of the service provided were completed and made available to the inspector. The information collated in the falls audit was analysed to identify times, frequency and location of each resident's falls. However, in the absence of overall trending, this information was not comprehensive or effective in informing specific areas needing improvement. For example, adequacy of available staffing resources to ensure supervision of residents in the sitting rooms was not explicitly reviewed as part of the analysis of residents' falls. Action plans were not consistently developed to provide assurances that areas identified in audits as needing improvement were completed.

The inspection findings did not provide sufficient assurances that staffing resources were informed by evacuation needs of residents in the event of a fire or emergency in the centre or in meeting residents’ needs include their assessed risk of falling.

Assurances regarding effective containment of smoke/fire in the event of a fire in the centre was also not available on inspection. The provider was required to take urgent action to provide the Chief Inspector with assurances that residents' safety would be assured in the event of a fire in the centre.

An annual review report on the quality and safety of care and quality of life for residents was prepared for 2018. The report was completed in consultation with residents.

Judgment: Not compliant
The centre's statement of purpose was recently revised with some minor revisions and contained the information as required by Schedule 1 of the Regulations. The staffing compliment reflected staff available in the centre.

Judgment: Compliant

### Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. All incidents of serious injury to residents were notified to the Health Information and Quality Authority (HIQA) as required within the specified regulatory timescales. Quarterly reports were submitted as required regarding occurrence of other incidents as detailed in the Regulations.

Judgment: Compliant

### Regulation 34: Complaints procedure

A policy was available to inform the management of complaints in the centre. The designated complaints officer for the service is a clinical nurse manager. There were some open complaints in progress and were at various stages of resolution. A record of all complaints received was maintained and included details of investigation and learning to be implemented. The record confirmed that the outcome of investigations was communicated to complainants and their satisfaction was recorded. Where complainants were not satisfied with the outcome of investigation, an independent appeals process was available.

Complaints received were reviewed at the centre's governance and management meetings. Residents who spoke with the inspector confirmed that they were aware of the complaints procedure and most said they would express their dissatisfaction or concerns to the person in charge. An independent advocacy service was available to assist residents if necessary.

Judgment: Compliant

### Quality and safety

Residents had good access to medical services including acute hospital and psychiatry services. In the absence of community physiotherapy, dietician and speech and language therapy services, the provider had put arrangements in place.
to ensure residents had timely access to these allied health professionals on referral.

A review of residents' care documentation demonstrated that residents' nursing care and healthcare needs were appropriately assessed and reviewed on a regular basis. Residents' assessed needs mostly informed person-centred care plans that were developed in consultation with them or their families on their behalf. Residents' care plans detailed their preferences and wishes regarding the care interventions they wanted prioritised for them. The provider employed a physiotherapist on one day each week. Part of the physiotherapist's role was to support staff with assessing and mitigating risk of falls to residents. While some measures were put in place to mitigate individual resident's assessed risk of falls, these measures were not comprehensive and were not effective. For example, several residents continued to experience repeated falls that were unwatched by staff in their bedrooms, in the communal sitting room and while self-propelling their wheelchair. The inspector found that increased staff supervision in areas where these residents were most vulnerable or referral of residents who had repeated falls from wheelchairs for occupational therapy assessment were not considered as measures to improve outcomes for these residents.

Proactive management of risk to ensure residents' safety and emergency evacuation needs would be met in the event of a fire was not available. Although staff who spoke with the inspector were knowledgeable regarding evacuating residents in the event of an emergency, assurances that this could be achieved were not available as the simulated emergency evacuation drills referenced evacuation of one bedroom only within a fire compartment. The inspector was told that eight residents were accommodated in the biggest fire compartment in the centre. There was also no arrangements in place to ensure residents' bedroom doors would be closed in the event of a fire in the centre. The arrangements for the containment of fire and smoke was not adequately considered as discussed under Regulation 28, Fire Precautions. The provider was required to address these findings urgently and provide the Chief Inspector with assurances that residents' safety needs would be met in an emergency. The provider's responses did not provide the necessary assurances in relation to fire safety.

The overall layout and design of residents' accommodation provided them with comfort and choice regarding their communal facilities and ensured they had sufficient space in their bedrooms and facilities to meet their needs. The centre was bright and spacious. Residents' access and independence was promoted with wide corridors, handrails on circulating corridors and grab rails in toilets and showers. Residents' privacy and dignity needs were met.

A safeguarding policy was in place and staff were facilitated to attend training on safeguarding residents from abuse. Staff who spoke with the inspector were aware of their responsibilities to report any suspicions, disclosures or incidents of abuse they may witness. The inspector observed that staff had developed good relationships with residents and were committed to ensuring residents' needs were met. Residents told the inspector that they felt safe in the centre and that staff were
always kind and respectful towards them. All interactions between staff and residents were observed by the inspector to be courteous and caring.

A small number of residents were periodically predisposed to episodes of responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). These residents were well supported. Some minor improvements were necessary in the information documented in some residents' behaviour support care plans. These improvements are to ensure all effective person-centred de-escalation strategies for individual residents were communicated to the staff team and consistently implemented. Restrictive practices were minimised in the centre and practices reflected the national policy guidelines.

Regulation 17: Premises

The layout and design of the centre met residents' individual and collective needs to a good standard. The centre premises was purpose built and extended over the years to provide 74 single bedrooms and two twin bedrooms. Residents' bedroom accommodation was arranged on ground floor level and was in close proximity to a variety of communal sitting rooms and dining areas. Handrails in a contrasting colour to surrounding walls were fitting along all circulating corridors to facilitate residents' independence with mobilising around the centre. Grab rails were fitted in toilets and showers to meet residents' safety needs. The centre was decorated in a homely and familiar style for residents and provided them with an accessible and therapeutic environment.

All parts of the centre premises were visibly clean, comfortable and in a good state of repair with the exception of some damage to the paintwork on handrails and on doors and door frames caused by passing equipment. The provider was addressing this. Residents’ bedrooms were bright and spacious. Residents’ were encouraged to personalise their bedrooms with their own paintings, photographs, ornaments and soft furnishings. This arrangement ensured residents could enjoy continued use of their favourite items in the centre. There was sufficient storage provided for residents’ clothes and possessions.

The sitting and dining areas were spacious and brightly decorated. Floor covering was non-slip, bright and non-patterned throughout the centre to promote the safe mobility of residents in the centre. Large windows throughout the centre promoted good use of natural light in communal areas and corridors. Corridors were wide to ensure that residents could mobilize safely when using a wheelchair or a walking frame.

The enclosed outdoor areas were accessible and were landscaped to a high standard making these facilities interesting and therapeutic for residents. Appropriate outdoor seating was provided.
Judgment: Compliant

**Regulation 20: Information for residents**

A guide was available to residents which reflected the services and facilities available to them in the centre and the arrangements for visits. The terms and conditions relating to their stay was included.

Judgment: Compliant

**Regulation 28: Fire precautions**

The provider had measures in place to ensure residents' safety in the event of a fire in the centre. However, the inspector's findings did not provide sufficient assurances that these measures would be effective in ensuring residents would be supported with timely evacuation to a place of safety and that a fire/smoke would be effectively contained.

Doors on communal rooms used by residents were fitted with self closure devices that ensured these door closed in the event of the fire alarm sounding. This ensured any fire or smoke was contained within these rooms. The inspector observed that most residents' bedroom doors were open. There was no arrangement in place to ensure residents' bedroom doors would be closed in the event of a fire in the centre. Some residents who spoke with the inspector said they liked to have their door open. One resident used a doorstop to keep their bedroom door open and their wishes were respected. Staff who spoke with the inspector regarding the actions they would take in the event of a fire did not speak about closing residents' bedroom doors and this arrangement was not documented as part of the emergency fire procedures in the centre. Appropriate arrangements for the containment of fire and smoke was not adequately considered.

The inspector was told that a system of horizontal evacuation was the emergency evacuation procedure in the centre. Simulated emergency evacuation drills were done regularly in the centre and the records were make available to the inspector. These records were examined by the inspector and referenced evacuation of one room and not evacuation of all rooms within one compartment to the next as would be the procedure expected in horizontal evacuation. Staff who spoke with the inspector articulated the procedure they would follow in the event of a fire in a bedroom selected by the inspector. Staff confirmed that they would aim to move the resident in the affected bedroom and residents in the adjacent bedrooms beyond the fire doors located in corridors. The provider had distinguished the fire doors on corridors with a red paint marking. The inspector was told that these doors were located on the boundary of the fire compartments in the centre. Residents' emergency evacuation staffing and equipment needs were assessed. This
information was documented as part of their manual handling procedure and was displayed inside the wardrobe doors in their bedrooms. This information did not include reference to the supervision needs of residents with medical conditions that impacted on their cognitive wellbeing.

The provider was informed that urgent action was required to ensure fire containment procedures were in place and to provide assurances that resident's evacuation needs would be met in the event of an emergency in the centre. Following the inspection, the provider engaged the services of a fire safety consultant.

A floor plan of the centre indicating fire compartment boundaries was not displayed by the fire alarm panel to inform evacuation procedures.

Fire safety management checking procedures were completed and records were made available to the inspector. While the inspector observed there were no gaps in the records of checks done, checking of the emergency lighting and signage was not referenced as part of the checking procedure in the centre. Documentation was available dated January 2019 referencing a service of the emergency lighting by a competent person with corrective actions outlined. Assurance was not provided to confirm that these actions were completed. Records of subsequent servicing of emergency lighting for 2019 was not made available. The centre's fire alarm was sounded on a weekly basis and quarterly service records of the fire alarm by a competent person were made available to the inspector.

Judgment: Not compliant

**Regulation 5: Individual assessment and care plan**

A sample of residents' care plans were reviewed by the inspector during the inspection. Each resident's needs were comprehensively assessed within 48 hours of their admission. Some effective de-escalation strategies used by staff to support a small number of residents with responsive behaviours were not consistently described in their behaviour support care plans. Staff used a variety of assessment tools including a falls risk assessment tool to inform the development of individual care plans. Residents' care plans were mostly person centred and detailed the care interventions that each individual resident wished to be prioritised regarding the care they received.

Some care plans lacked sufficient detail to support a consistent approach to care. Care plans for residents at risk of falling did not describe their individual supervision needs and many of the interventions described were not appropriate or effective to achieve the desired goal. Recommended placement of equipment to alert staff or to reduce the risk of injury to residents was not detailed in care plans to ensure its purpose was optimised for individual residents with an assessed risk of falling in their bedrooms. Some residents with medical conditions that severely impaired their
Cognitive function were advised to ring their call bell as a falls prevention strategy in the absence of a comprehensive assessment of their capability. For example, one resident with a severe cognitive impairment who had repeated falls was advised to ring their bell for assistance as a falls prevention strategy in the absence of assessment of capability. This required review.

Care plans for residents with diabetes detailed instructions regarding the frequency with which their blood glucose levels should be assessed but did not advise on the recommended parameters that their blood glucose levels should be maintained within or the corrective actions to take if outside recommended levels. Residents' care plans were reviewed at regular intervals and residents, or their family on their behalf, were consulted regarding their care plan development and subsequent reviews.

Judgment: Substantially compliant

**Regulation 6: Health care**

Residents were provided with access to general practitioners (GPs) as necessary. Residents in the centre were cared for by GPs from local practices as they wished. Residents had access to community palliative and psychiatry of older age services.

Community occupational therapy services were available to residents on referral. However, a resident who used a wheelchair to independently move around the centre sustained several repeated falls from their wheelchair and had not been referred for occupational therapy services for assessment with using this equipment. In the absence of community physiotherapy, dietician and speech and language therapy services, the provider had arrangements in place to ensure there was no delay in residents accessing these services. The provider recruited the services of a physiotherapist who attended the centre on one day each week. The physiotherapist completed assessments of residents' mobility needs, risk of falling and was involved in falls prevention in the centre with residents and staff. There was a focus on maintaining and optimising residents independence in the centre and the physiotherapist facilitated an exercise programme for them.

Residents were supported to attend outpatient appointments and to access national health screening programmes.

Judgment: Substantially compliant

**Regulation 7: Managing behaviour that is challenging**
A small number of residents were periodically predisposed to episodes of responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The provider ensured that staff were facilitated to attend training in supporting residents with managing responsive behaviours.

Behavioural support care plans were developed for residents with responsive behaviours. These care plans contained person-centred de-escalation strategies to guide staff with providing consistent support procedures. Staff knew residents well but some person-centred and supportive de-escalation strategies they described to the inspector were described in some residents' support care plans to ensure a consistent and effective approach to behaviours. This finding is discussed under Regulation 5. Individual assessment and care plan. Effective procedures were put in place to mitigate peer-to-peer incidents occurring.

Efforts had been made by the person in charge and staff to reduce bedrail use in the centre and this was seen to be effective and resulted in a reduction in the number of residents with bedrails in place. Residents' documentation confirmed that an assessment of need for full-length bedrails was completed and included details of alternatives tried. Safety assessments were completed to ensure bedrails were safe for residents to use prior to their implementation and while in use. Schedules were available detailing the frequency with which bedrails were removed.

Judgment: Compliant

**Regulation 8: Protection**

A policy was available and systems were in place to ensure residents were safeguarded and protected from abuse. Staff were facilitated to attend training in recognising and responding to a suspicion, incident or disclosure of abuse. Staff who spoke with the inspector were knowledgeable regarding the different kinds of abuse and clearly articulated their responsibility to report any concerns or disclosures.

All interactions observed by the inspector between staff and residents were respectful, courteous and kind. Residents who spoke with the inspector said that they felt safe in the centre and that staff were always kind and caring towards them.

Judgment: Compliant
Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

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<thead>
<tr>
<th>Regulation Title</th>
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<tbody>
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<td><strong>Capacity and capability</strong></td>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 16: Training and staff development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Notification of incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
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<tr>
<td>Regulation 17: Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 20: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 7: Managing behaviour that is challenging</td>
<td>Compliant</td>
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<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
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Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action within a reasonable timeframe to come into compliance.
Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

**Compliance plan provider’s response:**

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<thead>
<tr>
<th>Regulation Heading</th>
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<tr>
<td>Regulation 15: Staffing</td>
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Outline how you are going to come into compliance with Regulation 15: Staffing:

Regulation 15(1): The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.

Review of staffing is done when allocations are being divided out on a daily basis, and also with the compilation of rosters, to ensure supervision of all staff during work activities is appropriate, and, so that we can meet residents combined needs and dependency. This system has been demonstrated to work well and will continue.

The 2 staff referred to as being on unauthorized leave on the day:

This observation is incorrect, for clarification: On the day of inspection one member of staff was on unauthorized (sick) leave, another member of staff had permission to start work at a later time. The service on the day was not compromised due to the absent staff member. In the event that an adverse situation had arisen during the course of the day we had 9 Health Care Assistants at training on-site, undertaking Gerontology Fetac level 6, any of whom could have been called upon if the need arose.

Quality of care review will be completed with residents for year end, before the 31st January 2020.

Regulation 23(a): The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. (Will also be addressed under Regulation 23)

Staff will continue to check on residents during their shifts at regular intervals with the maintenance of half hourly checks, and this will be kept under review. We do not consider that it is person centered and respectful of residents right to freedom and choice to unilaterally insist people with certain risks have to be siloed into any particular areas, as residents have shown a preference to sit among our 6 various sitting rooms at different times and on different days.
As staff are attending to residents they are continuously observing the residents in all areas, but the centre still carries out half hourly checks on residents in the main sitting room where the register to be completed after the checks have been finalised is located. The inspector refers to prolonged periods without supervision despite the completion of the half hourly checks, however Mooncoin RCC does not routinely provide 1:1 care unless to address a specific need at a given time, nor does it undertake to do so in our Statement of Purpose.

‘The inspector has reviewed the provider compliance plan. The action proposed to address the regulatory non-compliance does not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.’

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<thead>
<tr>
<th>Regulation 23: Governance and management</th>
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Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23.(a)The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

A full review of all falls has taken place and residents who fall repeatedly have had actions as appropriate, yet person centered applied. A new system of recording first evidence of falls has been introduced for all staff to help with trending and analyzing patterns when repeat falls occur.

4 Sessions of falls training have been completed by staff within the centre, the training found to be comprehensive and very relevant, but also taking into account people rights under the FREDA principles and ensure not to deprive residents of their liberty and freedom of movement, but to support them by mitigating risks when possible.

The audit schedule is under review and will continue to be further developed to cover the comprehensive range of risks to be mitigated.

The service at MRCC is safe, appropriate, consistent and effectively monitored regarding fire safety as can be demonstrated through our training records in relation to fire which is delivered to our staff by a competent fire training specialist. The training syllabus is in compliance with the relevant guidance applicable.

MRCC has sufficient staff on duty to cater for the evacuation needs of our residents at all times. To further assure the inspector in relation to these concerns we have engaged the services of an independent fire safety consultant to assess our staffs capacity to execute a fire or emergency evacuation of our residents. The compartments evacuated during
training were done so simulating the night time staffing ratio. The findings of this assessment will be forwarded by 30/11/2019.

The containment of smoke/fire in the event of a fire at MRCC is wholly in compliance with our obligations as laid down under the laws applicable in this regard. The provider did respond to the Chief inspector with reasonably practicable timelines assuring the inspector that our residents safety can be ensured in the event of a fire in our centre. To further assure the inspector in relation to the concerns raised, we will be providing the full suite of documentation relating to the Fire Safety Certificate granted to us by the Kilkenny Fire Authority. This documentation has been requested from Kilkenny Fire Authority and will be forwarded immediately on receipt.

‘The inspector has reviewed the provider compliance plan. The action proposed to address the regulatory non-compliance does not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.’

<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
<th>Not Compliant</th>
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</table>
| Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Registered Provider has adequate arrangements in place for the maintenance of all fire equipment, means of escape, building fabric and building services and this is evidenced in the documentation available at our centre and provided to the inspectorate since the inspection. The Registered Provider will further improve the arrangements for reviewing fire precautions by reviewing and improving the documentation retained for inspection to clearly demonstrate to the inspectorate how we protect the safety health and well being of our residents in the event of a fire incident. The registered provider has adequate arrangements in place to detect, contain and extinguish fire, this is achieved by having a fully serviced and maintained Fire Detection and Alarm System on our premises. We contain fires with robust construction methods in accordance with the requirements of our Fire Safety Certificate which was granted by The Fire Authority in Kilkenny County Council. Extinguishment of Fires is achieved by having fire extinguishers strategically positioned around the centre and maintaining same in accordance with the relevant standards. To date the registered provider has provided fire training to all staff, which has included the safe evacuation of our residents from a place of danger to a place of safety. Following this inspection we have endeavoured to further improve our fire training to our staff which will deal exclusively with the arrangements necessary for evacuating residents to a place of safety in the event of a fire. In line with our updates on fire management, the evacuation of compartments etc, our
documentation of PEEP’s will be updated to reflect the findings from the various training sessions held.

‘The inspector has reviewed the provider compliance plan. The action proposed to address the regulatory non-compliance does not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.’

<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and care plan</th>
<th>Substantially Compliant</th>
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

All potential residents have a full comprehensive assessment carried out by the PIC prior to admission. This further informs the admission process and the follow up on admission is for development of appropriate care plans, for this person.

All residents in Mooncoin have a care plan in place within 24-48 hours of admission. This is reviewed when changes occur or at least 4 monthly. The inspector felt it was important for the one insulin dependent resident to have the parameters for the resident’s normal blood sugar range included in her care plan.

When the Resident’s GP was asked to specify what he deemed acceptable as this person has demonstrated a tolerance to high blood sugars that others may not, without the usual effects of a high blood sugar, the doctor has clearly stated he finds the HbA1c, a specific laboratory test, to be a more reliable alternative to peripheral blood sugars. For this reason he has prescribed a separate prescription if blood sugars are excessively high. This is completed and in place and the care plan updated to reflect this.

‘The inspector has reviewed the provider compliance plan. The action proposed to address the regulatory non-compliance does not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.’

<table>
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<tr>
<th>Regulation 6: Health care</th>
<th>Substantially Compliant</th>
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Outline how you are going to come into compliance with Regulation 6: Health care:

Regulation 6(2)(c): The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.

All residents are attended by a Doctor of their choice and always have been.
Medical treatment is supported and followed up by nursing and care staff within the centre.

Nursing staff are well supervised and promote individuals to get the best from their health care to maximize quality of life. To this extent allied medical practitioners are available and attend to residents in the center where at all possible, but otherwise residents are supported to attend outpatient clinics as required.

Mooncoin RCC has 78 residents. The layout allows for 74 single ensuite rooms and two twin rooms. As has happened with the evolution of purpose built NH’s, more falls do tend to occur in residents bedrooms. The centre has adopted a system to identify people who are at risk as per the falling leaf symbols which to meet this inspector’s preference are now all the same size. The residents who fall have a number of interventions which work for some but not for all and have to be applied in the least restrictive manner possible to include where suitable sensor mats to let staff know if someone is moving around so they can assist them, low beds, fall breaking mats to reduce the risk of injury (note these cannot be used by anyone who is mobile due to the increased risk of injury).

Those who are falling in their bedroom, are subject to a comprehensive review and we have introduced new documentation to look for patterns as to what the resident might be trying to achieve when getting up from bed that would enable staff to attend to this need without the resident getting up, and we have also introduced a comprehensive, multifactorial investigation record which identifies trends such as postural hypotension, falling due to infection etc. that will hopefully determine patterns when clusters of falls occur, resulting in having extra interventions in place where a specific pattern occurs.

The resident who has had numerous falls while self-propelling in his wheelchair had every trip and near miss documented. He has an expressed preference for freedom of movement and this has to be supported in line with his rights. The community Occupational Therapy Department has been asked to review his chair to see if there is anything more suitable for him, that will mitigate the risk of injury, while maintaining his independance, and a referral has been sent to the WICOP falls clinic by his GP to out rule physical issues that may be reversible if anything physical is contributing to the falls. The resident and his family have been involved in meetings with staff in relation to his falls, but there is still a clear preference for his freedom to be maintained and enabled, as this is how he likes to spend his day.

If the residents can benefit from a referral to the Falls Clinic in Waterford’s Integrated Care for Older People (WICOP) service, then we will ask their GP to refer them.
Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15(1)</td>
<td>The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>03/10/2019</td>
</tr>
<tr>
<td>Regulation 23(a)</td>
<td>The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>02/10/2019</td>
</tr>
<tr>
<td>Regulation 23(c)</td>
<td>The registered provider shall ensure that management systems are in place to ensure</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/11/2019</td>
</tr>
</tbody>
</table>
that the service provided is safe, appropriate, consistent and effectively monitored.

<table>
<thead>
<tr>
<th>Regulation 28(1)(c)(i)</th>
<th>The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.</th>
<th>Not Compliant</th>
<th>Orange</th>
<th>01/11/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 28(1)(c)(ii)</td>
<td>The registered provider shall make adequate arrangements for reviewing fire precautions.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>01/11/2019</td>
</tr>
<tr>
<td>Regulation 28(2)(i)</td>
<td>The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.</td>
<td>Not Compliant</td>
<td>Red</td>
<td>08/10/2019</td>
</tr>
<tr>
<td>Regulation 28(2)(iv)</td>
<td>The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/11/2019</td>
</tr>
<tr>
<td>Regulation 28(3)</td>
<td>The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>30/11/2019</td>
</tr>
<tr>
<td>Regulation 5(2)</td>
<td>The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to a designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>02/10/2019</td>
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<td>Regulation 5(3)</td>
<td>The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident’s admission to the designated centre concerned.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>13/11/2019</td>
</tr>
<tr>
<td>Regulation 6(2)(c)</td>
<td>The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/10/2019</td>
</tr>
</tbody>
</table>