

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Moycullen Nursing Home
Centre ID:	OSV-0000365
Centre address:	Ballinahalla, Moycullen, Galway.
Telephone number:	091 868 686
Email address:	moycullennursinghome@mowlamhealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mowlam Healthcare Services
Provider Nominee:	Pat Shanahan
Lead inspector:	Marie Matthews
Support inspector(s):	Geraldine Jolley
Type of inspection	Announced
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	6

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance 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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 April 2016 18:00	25 April 2016 21:00
26 April 2016 09:30	26 April 2016 19:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Substantially Compliant
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (HIQA) to renew registration of the designated centre.

The centre accommodates 54 residents who need long-term care, or who have

respite, convalescent or palliative care needs. There were 48 residents present at the time of this inspection. A further two residents were in hospital.

The inspector reviewed progress on the action plan from the previous monitoring inspection carried out in April 2014. The inspector met with the provider and person in charge who displayed a good knowledge of the Authority's Standards and regulatory requirements. A number of questionnaires from residents and relatives were received prior to the inspection and the inspector spoke to residents during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

The person in charge was fully involved in the management of the centre and was found to be easily accessible to residents, relatives and staff. There was evidence of a commitment to providing quality, person-centered care. Residents spoken with stated that they felt safe in the centre.

The inspectors found a good standard of evidence-based care and appropriate medical and allied health care access. Staff supported residents to maintain their independence where possible. There was evidence of individual residents' needs being met.

The premises, fittings and equipment were clean, well maintained and decorated. The building was comfortably warm. A wide range of activities was facilitated by an activity coordinator.

Inspectors identified some aspects of the service that needed improvement. Documentation in relation to nutritional intake records and turning charts and aspects of restraint management required improvement to reflect evidence based practice. Some end of life care plans also required review to reflect the needs of residents.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and 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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The Statement of Purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the regulations.

The Statement of Purpose was kept up to date and revised in January 2016. The provider has ensured sufficient resources to ensure the delivery of care in accordance with the Statement of Purpose. There was a defined management structure in place with which staff were familiar. The governance arrangements in place are suitable to ensure the service provided is safe, appropriate and consistent. There is reporting system in place to demonstrate and communicate the service is effectively monitored between the person in charge and the service provider.

Judgment:

Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a clearly defined management structure in place and inspectors saw that management systems were in place to ensure the service provided was safe appropriate to residents needs and consistently monitored.

A system of audits were completed on an annual basis which included a range of areas such as complaints, accident or falls sustained by residents, medication management, weight loss, restraint use and wound care. There was evidence of quality improvement strategies to improve services. A report on the quality and safety of care was completed annually and copies made available to the residents or their representative for their information as required by the regulations.

There was evident of regular management meetings between the provider nominee and the PIC and staff meetings.

Judgment:

Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):**Findings:**

Residents accommodated had a written contract of care which detailed the services to be provided and the fees payable by the residents. Inspectors reviewed a sample of contracts of care and found that they were signed by the resident or their next of kin and they clearly specified the amount paid by the Fair Deal Support Scheme. The contract of care outlined the range of services included in the fee and those which incurred an additional charge were included in an attached schedule. Additional expenses included support services such as chiropody, physiotherapy, speech and language therapy, occupational therapy, hairdressing and escort to appointments.

There was a residents' guide developed containing all the information required by the regulations. This detailed the visiting arrangements, the term and conditions of occupancy, the services provided and a copy of the complaints procedure was included..

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience.

The person in charge has not changed since the last inspection. She is a registered nurse and holds a full-time post. She had good knowledge of residents care needs and was well known by residents. She had protected time to ensure clinical governance and administration. She could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

The person in charge had maintained her professional development since the last inspection and had recently completed a post graduate diploma in professional studies in nursing care which included modules on wound care, quality management, tissue viability and clinical auditing in addition to mandatory training required by the regulations.

The person in charge is supported in her role by a senior nurse supervisor who deputises in her absence.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The directory of residents was reviewed and contained all the information required by schedule three of the regulations. Written operational policies, which were centre-specific, were in place to inform practice and provide guidance to staff.

Appropriate insurance cover was in place with regard to accidents and incidents, out sourced providers and residents' personal property.

An electronic care planning system was in use and records pertaining to residents were securely stored on this system and inspectors found that they were easily retrievable. Medical records and other records, relating to residents and staff, were also maintained in a secure manner.

A sample of staff files was found to contain all the information required by Schedule 2 of the regulations was available in the staff files reviewed. However, codes were used on the staff roster without any key to explain them and times were not recorded in a 24 hour format.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

A senior nurse deputised in the absence of the person in charge. The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment

is promoted.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There were procedures in place for the prevention, detection and response to abuse. This had been reviewed since the last inspection. The policy had been updated to reflect the new Health Service Executive (HSE) policy on Protection of Vulnerable adults.

Staff members interviewed by inspectors were clear on the signs to look out for and the different types of abuse which can occur. Staff identified the person in charge as the person to whom they would report a suspected concern. Inspectors viewed records confirming there all staff had completed training in protection of vulnerable adults which was an action from the last inspection.

There was a policy on restraint management (the use of bedrails and lap belts) in place. A restraint free environment was been promoted. At the time of this inspection there were 7 bedrails and no lap belts in use. A risk assessment was completed prior to using bedrails. Signed consent was obtained. There was evidence of multi disciplinary involvement in the decision making process.

When a resident requested a bedrail for use as an enabler, a risk assessment was completed to ensure it was safe to use. However the rational for how the bedrail assisted the resident was not clearly stated in the residents' care plan and some bedrail had been put in place at the request of the residents' family contrary to evidenced based practice. Residents with whom the inspectors were able to communicate verbally said they felt safe and secure in the centre, and felt the staff were supportive. Relatives spoken with felt their next of kin was being supported and receiving safe care.

Some residents had behaviours and psychological symptoms of dementia (BPSD). There was a policy in place for behaviour that is challenging, and staff had received training on understanding and managing behaviours that challenge. Staff spoken to by the inspectors were knowledgeable regarding interventions that were effective in managing such behaviours including redirection and engaging with the residents. There was evidence in care plans of links with the mental health services. Behaviours logs were being completed to identify triggers and to inform further planned reviews by the psychiatry team but there was no behavioural support plans with proactive and reactive strategies to direct care in a consistent manner.

There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. The person in charge acted as an agent for four residents. There were financial controls in place to ensure the safeguarding of residents' finances. A petty cash system was also maintained electronically for residents and small sums of residents' money was stored safely on their behalf. A record of the handling of

money was maintained for each transaction. Two signatures were recorded for each transaction. The ongoing balance was transparently managed.

Judgment:
Substantially Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
A risk management policy and a health and safety policy were available to guide staff and a health and safety committee was established with representation from all staff grades.

Suitable fire equipment was provided throughout the centre. There was documentary evidence fire equipment was serviced on an annual basis and the fire alarm was serviced on a quarterly basis. Staff spoken with were knowledgeable of the response to be taken if the fire alarm was activated or if the centre required evacuation. All staff had received training in fire prevention. On the previous inspection inspectors identified fire drills were not carried out regularly outside of fire training sessions. Inspectors reviewed fire safety documentation which evidenced that regular fire drills had taken place since the last inspection. The duration of each drill, the staff involved and the location of the drill were also recorded. The drill record also included the outcome and the learning from the drill.

Fire exits were observed to be unobstructed and corridors were clear of any items which could impede evacuation in the event of an emergency. Fire safety equipment including the fire alarm, fire fighting equipment, emergency lighting and smoke detectors were provided and were serviced quarterly and annually as required. Evacuation sheets were fitted to each bed and all residents had a personal emergency evacuation plan in place.

Clinical risk assessments were completed, including an assessment of the residents' risk of sustaining a fall, choking or experiencing weight loss. Other risks identified included those associated with dementia such as expressive behaviours or absconding were also identified and appropriately risk assessed. Record reviewed confirmed that missing person drills were completed twice a year.

There were moving and handling assessments available for all residents which were available in residents' bedrooms. All staff had up to date training in manual handling and in the use of the hoists and inspectors observed good moving and handling practice.

There were arrangements in place for recording and investigating of untoward incidents and accidents and in the sample of accident report forms reviewed, vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a suspected head injury. A post incident review was completed to identify any contributing factors.

The inspectors observed that the centre was clean and appropriate infection control procedures were in place including alginate bags for the laundering of soiled linen. The provider has contracts in place for the regular servicing of all equipment and the inspectors viewed records of equipment serviced. Equipment such as specialist beds, wheelchairs and mattresses were provided in accordance with residents' needs.

Judgment:
Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing, administration and disposal of medication. All staff had signed to confirm they had read the policy which was an action from the previous inspection.

Medication was supplied by a two local pharmacies residents were facilitated with their choice of pharmacist. All unused medication was returned to this pharmacy. Controlled drugs were stored safely in a double locked cupboard and stock levels were recorded at the end of each shift and recorded in a register in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1982.

Inspectors reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible and distinguished between once off medication and regular medication. The maximum dose over a 24 hour period was stated on the prescription sheets examined for PRN (as required).

The prescription sheets reviewed were clear, legible and distinguished between PRN and regular medication. The maximum amount for PRN medication was indicated on sample

of prescription sheets viewed by the inspector.

GP's reviewed each resident's medication every three months or more frequently should a change in residents' health occur. The inspector reviewed medical files and noted the medication review by the prescribing practitioner, which was documented in the sample of residents' medical notes examined.

Judgment:

Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspection evidenced a good standard of evidence-based care and appropriate medical and allied health care access. There were 48 residents accommodated in the

centre at the time of the inspection. 18 residents had maximum dependency care needs. Nine residents were assessed as highly dependent and 14 had medium dependency care needs. Six residents were assessed as low dependency. The centre provides long stay, respite and convalescent care for older people. There were also a number of younger residents with multifunctional illness and conditions that effect memory and different dependencies accommodated.

The PIC stated that a social care model was been promoted in the centre and two social care practitioners were recently recruited to promote this ethos.

Residents had timely access to allied health professionals to include speech and language therapist and dietician. The provider employs a physiotherapist who visits the centre one day each week and an occupational therapist visits one day per month. The physiotherapist is available to review all residents and undertake individual exercises to promote mobility. Where required each resident has a personalised exercise program developed. The occupational therapist undertakes rehabilitative programs to assist residents maintain physical and sensory skills. The occupational therapist assists residents participate in the activities program available to them.

An electronic system was in use for care planning. Inspectors viewed a sample of residents' care plans on this system. Touch screen tablets were located throughout the centre and health care assistants inputted details of the residents daily routine such as any social activities attended, meals taken etc on these. A daily report on nursing care was also completed on this system.

Residents at risk of falls were regularly assessed also using a specific assessment tool. These were reviewed and updated as required as evidenced in a selection of care plans reviewed.

Inspectors reviewed aspects of 12 resident's care in total. A range of risk assessments had been completed and these informed the care plans. In general, care plans reviewed were person-centred and described the current care to be given. There was evidence that care plans were updated at the required four monthly intervals or in response to a change in a resident's health condition. There was evidence of consultation with residents or their representative in most care plans reviewed.

Medical records evidenced that residents were seen by a general practitioner (GP) within a short time of being admitted to the centre and in general there was evidence of regular medical reviews in the medical notes of most residents, however a small number hadn't been reviewed in more than 3 months. The person in charge stated that she had written to the GP's requesting that they review their patients and residents were offered the services of a local GP but declined this offer.

There were three residents with pressure or vascular wounds at the time of this inspection. The inspector reviewed the care plan for two residents. A plan of care was in place and regularly revised. Assessment evidenced the progress of the wounds. Residents were provided with pressure relieving air mattresses and cushions and were regularly repositioned. Care staff completed repositioning charts for residents with poor skin integrity but on review inspectors found that these were poorly completed and

several gaps were evident in all of the charts reviewed. An action has been included under outcome 5 requiring the provider to address this.

There were 13 residents with a diagnosis of dementia. Inspectors observed the day to day care of residents with dementia was very good and staff were observed to be patient and they promoted their independence and dignity and ensured that there was meaningful engagement provided. However, the way in which dementia impacted on residents was not always clearly described in care plans and it was difficult to see how it was assessed. For example, level of dementia the resident presented with or the level of orientation the resident retained was not recorded.

Where residents had specialist care needs such as mental health problems there was evidence in care plans of links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum health.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):

Findings:

The centre was designed to meet the needs of older people and those with acquired brain injury. It was well maintained, warm, comfortably decorated and clean.

There was a good choice of communal areas for residents to relax. Two dining areas were provided. Toilets were located close to communal areas for residents' convenience. Other facilities include a room where residents can meet visitors in private and an oratory.

There were 44 single bedrooms and three double rooms with ensuite facilities. A further 4 single rooms did not have ensuite facilities. Bedrooms were spacious and were suitably adapted in layout and equipped to assure the comfort and needs of residents. A call bell system was provided beside each resident's bed. Suitable lighting was provided and switches were within residents reach. Lockers were provided for the

storage of personal belongings. Bedrooms were personalised to reflect the residents' tastes with family pictures displayed

There were a sufficient number of accessible toilets, baths and showers provided for use by residents. There were ample corridors for residents to walk around freely and handrails were provided on all corridors to assist residents. A safe enclosed landscaped garden was available with raised flower beds and residents were observed to use this area during the inspection to residents.

Judgment:
Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors spoke with residents during the inspection who confirmed that they would have no hesitation in making a complaint if the need arose and said they would feel comfortable speaking to any staff member.

There was a complaints policy in place which included the steps involved in making a complaint and included details of an independent appeals process. The policy stated that all complaints were acknowledged within 5 working days and this was found to be the case. The timeframe for responding to a complaint was included in the complaints procedure which was displayed in the foyer of the centre.

Inspectors reviewed the centres complaints log which was maintained electronically. Seven complaints were recorded in the previous 4 months. All complaints had been investigated and were resolved. Records showed that in general, complaints were investigated promptly and resolved to the satisfaction of the complainant. The outcome for the complainant and whether the complainant was happy with the outcome was clearly stated in the complaints reviewed.

An independent appeals process was included in the policy if the complainant was not satisfied with the outcome of their complaint.

Judgment:
Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Medical files reviewed indicated that meetings were held with the resident or their next of kin and their General Practitioner's, (GPs) to discuss end of life care with the resident. Staff had completed training to enable them to administer subcutaneous fluids to prevent dehydration and in percutaneous endoscopic gastrostomy (PEG) tube replacement in order to avoid unnecessary hospital admissions and allow residents to remain in the centre at the end of their life if this was their preference. Most residents had their own bedrooms. Staff confirmed that where a resident was at the end of life in a shared bedrooms, they were facilitated with a single bedroom.

Resident's end-of-life care preferences or wishes were identified and documented in their care plans. Some resident's had an advanced care directive completed giving very comprehensive details regarding their preferences for end-of-life care; however, inspectors also identified some residents care plans which were generic and had not been adapted to reflect the end of life wishes and lacked sufficient detail regarding their physical, emotional, social and spiritual needs or the resident's preferred pathway at the end of their life.

A system was in place to ensure residents with a 'do not resuscitate (DNR) status in place have the status regularly reviewed to assess the validity of the clinical judgement on an on-going basis.

The person in charge confirmed they had good access to the palliative care team who provided advice to monitor physical symptoms and ensure appropriate comfort measures. There were no residents under the care of the palliative team at the time of this inspection.

Judgment:

Substantially Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors observed residents having their meals in the dining rooms and noted that meals were hot and well presented. Catering staff were on duty from 7am until 7pm however, the kitchen was open 24hrs per day and snacks were freely available.

Residents told inspectors that they enjoyed the food in the centre and that they could have tea or coffee and snacks any time they asked for them. They described a flexible approach to meal times and one resident told inspectors that he had always had his main meal in the evening and catering staff were facilitating him to carry on his established routine in the centre and served him his main meal in the evenings.

Inspectors found that a nutritious and varied diet was provided to residents which incorporated a choice at each meal. Residents' food likes and dislikes were recorded and meals served in accordance with their preferences and dietary restrictions. There was a choice for all residents to include those on pureed diet.

Residents who had an impaired swallow were reviewed by a speech and language therapist and staff assisted them with their meals. A list of residents on special diets including diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids was available to catering and care staff. Inspectors met with the chef, who had a good knowledge of the specific nutritional needs of residents.

All residents were screened for nutritional risk on admission using a recognised assessment tool. Inspectors saw that residents' weights were checked monthly or more frequently where indicated. Where residents were identified as been at risk nutritionally they were referred to a dietician. Inspectors reviewed one resident however who despite losing weight persistently had not been referred to a dietician since 2014 for review. An action has been included under outcome 11 requiring the person in charge to address this.

Resident at risk of weight loss were given a high calorie diet and catering staff confirmed that meals were fortified with cream, butter and nutritional supplements to increase the calorie content. Food and Fluid intake charts were maintained for these residents but on review inspectors found that these were not completed in sufficient detail to provide a reliable therapeutic record of the residents' nutritional intake over a 24 hour period.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The residents who spoke with inspectors said they were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. Some residents chose to have their breakfast in bed and inspectors observed residents coming to the dining room throughout the morning. Inspectors observed that staff interacting with residents in a respectful manner and respected their privacy during personal care. There were locks on all bathroom and bedroom doors. There was a visitor's room to allow residents meet with visitors in private.

Staff promoted residents mobility. During the day residents were able to move around the centre freely. Some residents with dementia were observed to continuously walk around the centre. Care staff chatted to these residents and encouraged others to walk for exercise to encourage their mobility.

Residents who spoke with the inspector positive about the meals provided and described choice and variety. Questionnaires completed by residents and relatives submitted to HIQA prior to the inspection also confirmed satisfaction with the quality and safety of care provided by the service.

Residents' civil and religious rights were respected. Residents confirmed that they had been offered the opportunity to vote in the recent national election and several residents were monitoring the progress of the new government. Residents also told inspectors they had participated in completing the census recently.

Residents could practice their religious beliefs and mass was celebrated on the second day of the inspection which most residents' participated in.

There was a structured program of activities in place which was displayed in large font in the sitting room. The activity schedule provided individual one to one activities for residents with dementia. The schedule was facilitated by the activities coordinator. Inspectors spoke with the activity coordinator who confirmed the range of activities in the weekly program.

Residents interviewed by inspectors were very positive regarding the opportunities

provided for them to have meaningful occupation. There were a variety of opportunities available and residents were observed participating in activities such as knitting, crochet, arts and crafts, card playing, baking and gardening. A variety of national and local newspapers and magazines were provided for residents and inspectors observed one scheduled activity which involved discussions about the news from various townlands from the local newspaper.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

There was evidence that residents had adequate space for their belongings, including secure lockable storage. Each resident was provided with their own wardrobe. The centre provided the service to laundry all residents' clothes and families had the choice to take home clothes to launder if they wished.

A staff member was assigned to the laundry each day of the week. A clear system was in place to ensure all clothes were identifiable to each resident. A property list was completed with an inventory of all residents' possessions on admission. The property list was updated at regular intervals.

Judgment:
Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The action from the previous inspection in relation to information required for staff working with vulnerable adults was addressed. A sample of four staff files was reviewed. All the information required by Schedule 2 of the Regulations including three written references, was available in each staff file. There was a policy available on the recruitment, selection and vetting of staff. The staff files were well organised and the information easily accessible.

The provider employs a whole-time equivalent of 45 staff. This was made up of 2 senior nurses, 9 registered nurses, 3 social care practitioners, 23 care attendants. In addition, there was catering, cleaning, laundry, activity coordinators and an administration staff member employed. The inspectors found that the numbers and skill mix of staff was appropriate to the assessed needs of residents and the size and layout of the centre on the day of inspection.

Inspectors reviewed the actual and planned staff roster and the staff numbers on the day correlated with the roster. However, codes were used on the roster without any key to explain them and times were not recorded in a 24 hour format. An action has been included under outcome 5 requiring the provider to address this.

Residents and staff spoken with expressed no concerns with regard to staffing levels. Staff were available to assist residents and residents were supervised at all times.

There was a policy available for the recruitment, selection and vetting of staff. Newly recruited staff undertook a period of induction and yearly appraisals were evident.

A training matrix available was available which conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on dementia care, infection control, wound care and medication.

Judgment:

Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Marie Matthews
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Moycullen Nursing Home
Centre ID:	OSV-0000365
Date of inspection:	25/04/2016
Date of response:	06/07/2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Codes were used on the staff roster without any key to explain them and times were not recorded in a 24 hour format.

1. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Please state the actions you have taken or are planning to take:

The Roster will be printed out from the TMS system from the 20th June 16. This format will have no codes and will be written in 24hr format.

Proposed Timescale: 20/06/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Repositioning charts for residents with poor skin integrity and food and Fluid intake charts were not completed in sufficient detail to provide a reliable therapeutic record and several gaps were evident in all of the charts reviewed.

2. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

PIC and Senior Care staff will supervise and monitor documentation of care to ensure full compliance and appropriate care planning interventions.

Proposed Timescale: 30/06/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Behaviours logs were being completed to identify triggers and to inform further planned reviews by the psychiatry team but there was no behavioural support plans with proactive and reactive strategies to direct care in a consistent manner.

3. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:

All residents displaying BPSD (Behavioural and Psychological Symptoms of Dementia) will be fully assessed in line with their care needs. A multidisciplinary approach will be taken to ensure that a non-restrictive plan is developed and maintained. The Clinical and social care teams within the home will guide and supervise practice. The

comprehensive assessment and care plan will be used to direct care and to further develop the care plans in situ for the residents.

Proposed Timescale: 30/07/2016

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The rationale for how the bedrail assisted the resident was not clearly stated in the residents' care plan and some bedrail had been put in place at the request of the residents' family contrary to evidenced based practice.

4. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:

The rationale for the use of a bedrail will be more clearly identified in the resident's care plan. The documentation in relation to developing the care plan and the consent documentation has be updated in line with national policy

Proposed Timescale: 30/06/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The way in which dementia impacted on residents was not always clearly described in care plans and it was difficult to see how it was assessed. For example, level of dementia the resident presented with or level of orientation the resident retained was not recorded.

5. Action Required:

Under Regulation 05(2) you are required to: 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 the designated centre.

Please state the actions you have taken or are planning to take:

All residents have a comprehensive and person centred assessment of care needs and a care plan in situ developed by our social and clinical care professionals. This is completed for all residents on admission and reviewed every 3 months and as required.

Care plans are structured using the Roper, Logan and Tierney model of care which is based on the 12 activities of living. The residents with a diagnosis of dementia have a particularly detailed Social, Emotional and Mental wellbeing care plan which is developed with the residents and their representatives. The social assessment 'a key to me' is completed on admission. The 'level' of dementia or orientation is not formally assessed or recorded on admission. Assessing the level of dementia is very subjective. A resident's behaviour is monitored through ABC charts, Cognition is assessed with MMSE when appropriate, Cohen Mansfield agitation inventory is used to measure levels of agitation. On admission, residents can be disorientated and display symptoms of dementia related to exposure to a new environment. A general pre-admission assessment is carried out and documented for all residents. Inspection of these documents was not requested.

Proposed Timescale: 10/06/2016

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents did not have regular medical reviews recorded in the medical notes

6. Action Required:

Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

Please state the actions you have taken or are planning to take:

2 residents had not been reviewed by their GP within the regulatory time period of 3 months. Nursing staff liaised closely with these GP's. Nursing staff verbally requested that the GP's attend to review their patients. GP's refused. Residents and their representatives were offered the services of a local GP but they refused. PIC wrote to GP's requesting that they review their patients. Letter to GP on file in residents charts. PIC will ensure that residents will be attended to by a GP that is acceptable to the resident.

Proposed Timescale: 10/06/2016

Outcome 14: End of Life Care

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents care plans which were generic and had not been adapted to reflect the end of life wishes and lacked sufficient detail regarding their physical, emotional, social and spiritual needs or the resident's preferred pathway at the end of their life.

7. Action Required:

Under Regulation 13(2) you are required to: Following the death of a resident make appropriate arrangements, in accordance with that resident's wishes in so far as they are known and are reasonably practical.

Please state the actions you have taken or are planning to take:

The language used in the development of the residents End of Life care plan is carefully worded in order to ensure a sensitive and appropriate tone. The text is used as a framework for the care plan to guide clinical and social care staff and was developed from the HIQA Standards in relation to end of life care. All end of life care plans are developed directly with the residents and their representatives. All End of Life care plans are signed by the resident and their representative to ensure that they reflect the wishes of the resident. The detail in the care plan is the detail given to the clinical and social care staff when developing the care plan. All Social and clinical care staff will be encouraged and facilitated to further develop their care planning skills and to ensure continuous quality improvement.

Proposed Timescale: Ongoing 30/06/2016

Proposed Timescale: 30/06/2016

Outcome 15: Food and Nutrition**Theme:**

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Food and Fluid intake charts were maintained for residents at nutritional risk as per their care plans but on review inspectors found that these were not completed in sufficient detail to provide a reliable therapeutic record of the residents' nutritional intake over a 24 hour period.

8. Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:

PIC and Senior Care staff will supervise and monitor documentation of care to ensure full compliance and appropriate care planning interventions. Training will be provided to all care staff so as to ensure high quality documentation of care.

Proposed Timescale: 15/07/2016