

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Moy Ridge Nursing Home
<b>Centre ID:</b>	OSV-0000364
<b>Centre address:</b>	Ridgepool Road, Ballina, Mayo.
<b>Telephone number:</b>	096 218 86
<b>Email address:</b>	moyridgepic@sonas.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Storey Broe Nursing Service Limited
<b>Provider Nominee:</b>	Seamus Crawley
<b>Lead inspector:</b>	Mary McCann
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	43
<b>Number of vacancies on the date of inspection:</b>	3

## **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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**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 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
11 July 2017 09:00	11 July 2017 18:30
12 July 2017 09:00	12 July 2017 13:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This report sets out the findings of an unannounced inspection which took place following receipt of unsolicited information and to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. One area detailed in the unsolicited information was found to require review, this related to the need to provide a structured safeguarding plan to ensure the care and welfare of residents is protected in the centre.

This was the ninth inspection of this centre. Previous inspection reports can be accessed at [www.hiqa.ie](http://www.hiqa.ie).

An announced registration renewal inspection had previously been carried out by HIQA in September 2016. There were six actions documented post this inspection. These included consultation with residents and or their relatives where appropriate regarding review of care plans, consultation with residents and relatives regarding the annual review of the quality and safety of the service. Contracts of care for residents require review to ensure they comply with current legislation. Other issues included realignment of the privacy curtains in twin rooms and affixing locks to ensuite doors to enhance residents' privacy. Five actions were addressed. One action was partially addressed, this related to the provision of appropriate screening to protect the privacy and dignity of residents in shared rooms. The centre is registered to provide care to 46 residents, 43 residents were residing in the centre at the time of this inspection

Moyridge Nursing Home is a purpose built residential care facility. It is situated in the town of Ballina and contains 17 double rooms and 12 single rooms. All bedrooms have en-suite facilities. There are 3 additional toilets, a bathroom, smoking room, kitchen, dining room, and 2 day/rest rooms. An oratory, hairdressing room, clinical room, storage area and laundry room complete the structural make-up. A secure enclosed outdoor garden is also available.

There were sufficient resources to ensure the delivery of care was in accordance with the Statement of Purpose. The health and social care needs of residents were met. There were an adequate complement of nursing and care staff on duty on the days of inspection. The inspector met with residents, the person in charge, one of the directors of the provider company who is the care centre coordinator. (The provider nominee was not available) and staff.

The action plan at the end of this report identifies some improvements that are necessary 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 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 Standards for Residential Care Settings for Older People in Ireland.**

***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):**

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

**Findings:**

This centre has had a change of provider nominee since the last inspection. Lines of accountability and authority were evident in the centre. Staff were aware of who was in charge and what the reporting structure was. The person in charge stated that the provider nominee attended the centre on a weekly basis and was freely available by phone and a formal monthly meeting was held between the provider and person in charge. The last meeting was held on the 7 July 2017.

Minutes of these meetings were available to the inspector, matters discussed included on-going redecoration and refurbishment, training needs of staff and audit outcomes. No evidence was available that the recent safeguarding incident had been discussed and what plans were necessary to protect residents.

Systems were in place to ensure that the service provided was safe and effectively monitored. For example staff had received training in infection control, fires safety, safe moving and handling and adult protection. The inspection evidenced residents have timely referral to healthcare services including specialist services, weekly access to physiotherapy services and timely access to medical staff.

Audits were completed to review all accident or incidents. Falls were reviewed to try and identify any causative factors to assess for trends to be easily identified and ensure learning for all staff and implement risk minimisation strategies to lessen the likelihood of reoccurrence.

Nutritional audits were completed. Actions were identified in relation to any unintentional weight loss or gain and individual assessments and care plans were reviewed.

An annual review of the quality and safety of care delivered to residents was available. This had been discussed at a residents meeting, however there was poor evidence available of improvements brought about as a result of the monitoring review. No quality improvement plan was completed post this review.

**Judgment:**

Substantially 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):**

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

**Findings:**

A sample of residents' contracts of care was reviewed by the inspector. The action from the previous inspection had been completed. The contracts have been reviewed and now set out the services to be provided. Fees charged to the resident were set out. An additional fee is charge for hairdressing, chiropody, activities and physiotherapy. The care centre coordinator confirmed that this was a voluntary contribution and if residents did not wish to pay they were invoiced for services individually.

**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:**

A new person in charge has been appointed since the last inspection.

She fulfils the criteria required by the regulations in terms of qualifications and

experience. She is a registered general nurse having qualified in 1994 and has completed a special purpose award in gerontology. She has worked continuously in elderly care since 1999. She has worked in the centre since 2009 initially as a staff nurse and more recently as worked as assistant director of nursing. She was detailed on the roster as working 08:00- 16:30 Monday to Friday and was on call every second week.

She had good knowledge of residents care needs. She could describe in a detailed way which residents had specific needs and how staff ensured that their care needs were met appropriately. The person in charge has maintained her professional development and has recently attended course in care planning and health and safety mandatory training required by the regulations.

There is dedicated time allocated to manage the governance and administration duties required by the post of person in charge.

**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:**

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were available for review by the inspector. They were stored in a secure manner. Samples of records were reviewed by the inspector.

An electronic directory of residents which included all the information specified in Schedule 3 was available. This was updated according to admissions, discharges, deaths or transfers.

The complaints procedure was displayed inside main entrance for visitors to view and provided guidance on how to make a complaint.

An up to date certificate of registration which included current personnel was displayed

prominently in the centre.

All records requested by the inspector were made available.

**Judgment:**

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:**

The care coordinator 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. A new deputy has been appointed to deputise for the person in her absence. She has the appropriate experience and knowledge to fulfil this post having worked as a person in charge at a sister centre. She is a registered nurse with many years experience in the field of elderly care.

Recent courses completed included dementia awareness, fire safety, medication management and cardiac first response.

**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):**

No actions were required from the previous inspection.

**Findings:**

Measures were in place to safeguard residents. The centre had a policy on safeguarding vulnerable adults at risk of abuse which had been approved by the previous provider representative in December 2015. All staff had received training in safeguarding vulnerable adults. A notification of an allegation of abuse had been submitted to HIQA. HIQA had also received unsolicited information with regard to this incident. This allegation had been investigated.

The inspector noted that staff had not been offered refresher training in adult protection post this incident. The person in charge and care coordinator stated that the staff involved in the incident had not returned to work since the incident but would be offered training on return. On the first day of inspection staff informed the inspector that Crisis prevention intervention training was scheduled for all staff. The care coordinator has now arranged for refresher training on detection prevention and response to abuse to form part of this training.

A robust structured safeguarding supervision and support plan had not been developed as per recommended in the further action required post the investigation by the investigation team. The person in charge and her deputy gave a firm commitment to address this. They stated that this would involve training supervision and management oversight.

Behaviour management care plans were in place to guide staff when working with residents who had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The records viewed confirmed that responsive behaviours were assessed and managed in the centre. Behaviour support plans were in place. The inspector read a sample of care plans and saw that they identified potential triggers and contained sufficient detail about appropriate interventions to guide staff to provide consistent person-centred approaches to care. Residents had free access to a secure garden and two sitting rooms and a dining room where they could spend time if they required peace and quiet or stimulation. Files examined showed that a pre-admission assessment had been completed in all cases to ensure that the centre could meet the needs of the residents. There was evidence that appropriate referrals had been made to mental health services and residents had accessed mental health services.

Bed rails were in use at night but these were used as enablers and the majority were used to allay the anxiety of the resident from rolling out of bed or to assist the resident with turning. One of the nursing staff had recently completed a course on restraint/bedrail management and stated that she was going to review all the care plans in this area with taking into consideration the Capacity Act and best practice in this area.

Some residents were using sensor alarms and low bed. Risk assessments were in place prior to the use of the bedrails.

A visitor's book was maintained and all visitors were required to sign in and out of the centre.

The administrator took the lead in the management of residents' finances. The centre had no money in safe keeping for residents. Any extra costs were invoiced at the end of each month. The administrator stated that the centre was not an agent for any resident but described how one resident's pension is paid directly to the company as part of her fees. She stated that was a long standing agreement. This was discussed with the care coordinator who gave a verbal commitment to review this arrangement and ensure that it complied with the best practice guidelines.

**Judgment:**

Non Compliant - Moderate

***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:**

The action from the last inspection with regard to the provision of smoking aprons was addressed. A fire extinguisher and a steel bin for safe disposal of cigarette ends was available in the smoking room. There was good availability of observation by staff of the smoking room as there were glass windows and doors off the corridor into the smoking room.

A centre specific risk management policy was available. This was in the process of being reviewed. An environmental risk register was also available. Where risks had been identified and control measures put in place these risk assessments were not regularly reviewed. Clinical risks specific to individual residents were detailed in their care plans, these included risks associated with falls, swallowing difficulties, loss of weight and risk of skin breakdown. These assessments informed the care plans and were regularly reviewed.

The inspector found that all internal fire exits were clear and unobstructed during the inspection. A fire evacuation plan was in place. This provided guidance to staff as to how to safely evacuate. Staff had completed refresher training in fire safety evacuation procedures. However, the procedures with regard to the recording of fire drills require review. The fire drill records did not record the scenario or type of simulated practice, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario or whether evacuation had taken place and if there were any impediments to safe evacuation. Consequently there was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required to ensure safe evacuation would be attainable if the need arose. Additionally there was no documentation to support that simulated fire drills had been completed with night staffing levels.

Fire safety checks were completed by staff on a weekly basis to ensure fire exits were unobstructed and emergency lighting was in place. Residents were assessed for risk of falls on admission and post a fall and on a four monthly basis if no fall occurred. Care plans were developed to mitigate risk. A falls prevention checklist was in place with care plans and assessments reviewed post each fall to try and mitigate the risk of reoccurrence. Records confirmed that neurological observations were completed post completed if a resident hit their head or if the fall was unwitnessed.

The inspector reviewed the accident and incident records. A record was maintained for each incident or accident. All accidents/incidents were reported to the provider representative. These were discussed at the monthly provider/person in charge meetings.

Regular falls audits were completed. The environment was well maintained with wide corridors with hand rails on both sides. Residents' bedrooms and communal areas were clutter free with no trailing cables which could pose a tripping hazard to residents. There was good non verbal signage in place for toilets and bathrooms to assist residents to easily identify and independently access as required.

Arrangements in place for infection control were consistent with the national guidelines and standards for the prevention and control of healthcare-associated infections. Staff had access to hand sanitizers throughout the centre.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

All Nursing staff had completed medication management training and this was completed on an annual basis. The inspector observed one of the nursing staff on part of their medication round and found that medication was administered in accordance with the policy and An Bord Altranais agus Cnáimhseachais Na hÉireann (Nursing and Midwifery Board of Ireland) guidelines. There were operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. All medications that were being crushed were prescribed as safe to crush. Medications that required strict control measures (MDAs) were counted by two nurses at each change of shift.

There was photographic identification on the front of each resident's prescription chart. There was evidence that the pharmacist attends the centre regularly, carries out medication audits, is available to residents and offers training to staff. The General Practitioner's signature was present for all medication prescribed with dates and signature of the general practitioner for discontinued medication documented. Maximum does of PRN (as required medication) was recorded.

**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 found that the centre has failed to adhere to the legislative requirement to submit some notifications to the Chief Inspector within three days of the occurrence of the event. For example an NF06 notification with regard to an allegation of abuse which was reported to the person in charge on the 31 May 2017 was not received by HIQA until the 14 June 2017, an NF03 notification with regard to 'any serious injury to a resident that requires immediate medical and/or hospital treatment' which occurred on the 18 Jan 2017 was not received by HIQA until the 26Jan 2017. There were other examples of notifications not been received with the statutory timescale.

**Judgment:**

Non Compliant - Moderate

***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):**

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

**Findings:**

The action from the last inspection with regard to consultation with residents and/or their relatives had been addressed.

There was evidence that timely access to health care services was facilitated for all residents. The deputising person in charge confirmed that a number of GPs were currently providing a service to the centre. An "out of hours" GP service was available if required. A narrative record was recorded for residents each day. This gave an overall clinical picture of the resident. The activity staff kept separate records with regard to social care engagement of residents. There was good evidence of transfer of information between the centre and acute healthcare providers. Discharge summaries for those who had spent time in acute hospitals was. An evidenced based strategy was in place to prevent falls whilst also promoting residents' independence. A physiotherapist visited the centre weekly. Allied health/specialist services such as speech and language therapy, dietetics and chiropody was available and there was evidence of referral and review.

A computerised care package system was in place. The inspector reviewed a selection of care plans. A pre-assessment was undertaken prior to admission. On admission, a comprehensive assessment of resident's abilities and needs was completed to include all activities of daily living, including risk of falls, nutritional care communication, personal care, mood and cognitive status. Overall, the inspector found that care plans were person centred with residents likes and dislikes recorded. Where a resident was seen by a specialist service the advice of the specialist was incorporated into the care plan. Care plans were kept under review as required by the resident's changing needs or circumstances and were reviewed no less frequently than at four-monthly interval.

There were no residents with wounds at the time of inspection. Where residents were deemed to be at risk of developing wounds preventative measures were identified including skin care regimes. Supportive equipment such as specialist cushions, mattresses and dietary supplements also formed part of the care package.

**Judgment:**

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):**

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

**Findings:**

The actions from the previous inspection had been completed.

On exit from the centre to the enclosed garden there is a slight incline, a hand rail had been erected to promote the safety and maintain the independence of residents.

at the time of the last inspection there were no locks on some of the en-suite shower and toilets to ensure the privacy and dignity of residents was protected. Locks had been fitted to all en-suite doors.

**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):**

No actions were required from the previous inspection.

**Findings:**

Policies and procedures which comply with legislative requirements were in place for the management of complaints. The procedure was on display in a prominent position in the main reception area. The nominated person to deal with complaints was the person in charge. there were two complaints recorded since the last inspection. Both of these were addressed in a time fashion and there was evidence documented that the complainant was satisfied with the outcome of the complaint. Complaints are discussed on a monthly basis at the person in charge /provider meeting.

A second person was nominated to hold a monitoring role to ensure that all complaints are appropriately responded to, and records are kept. An appeal process was available and this was documented in the in the procedure displayed for residents, relatives and visitors.

**Judgment:**

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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The action plan from the last inspection report contained an action with regard to the provision of curtains in twin bedrooms. These curtains did not protect the residents' privacy fully. While they divided the rooms, if a resident wished to use the en-suite facilities when the other resident was in bed they had to go through their private space. This action was partially completed. Some of the bedrooms had new rails and curtains erected. Staff informed the inspector that this an on-going project and all curtains in twin rooms were going to be renewed as part of a refurbishment programme. There was evidence that this had been discussed in management meetings.

**Judgment:**

Substantially 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):**

No actions were required from the previous inspection.

**Findings:**

At the time of inspection there were 43 residents residing in the centre, 23 of which were assessed as maximum dependency, nine as high dependency, five as medium dependency and six as low dependency. The Inspector reviewed the staff rosters. Where staff were unable to work this was recorded and staff were replaced with staff

who worked in the centre. No agency staff were employed.

There was a planned and actual roster in place. The inspector reviewed the actual and planned staff roster and the staff numbers on the day correlated with the roster. Residents and staff spoken with expressed no concerns with regard to staffing levels. Staff were available to assist residents and residents were supervised in the sitting and dining rooms. Residents were complimentary of the staff and staff "they are great, they will always help you, they are always in good form and will never rush you". Based on observations, a review of the roster and these inspection findings, the inspector was satisfied that the staff numbers and skill-mix were appropriate to meeting the assessed needs of the complement of residents accommodated. A registered nurse was on duty at all times.

The normal allocation of staff on duty was the person in charge and or the assistant director of nursing and two nurses and seven care assistants up to 14:00hrs, two nurses and five carers from 14:00 until 18:00hrs and one nurse and four care assistants up to 21:00hrs. On night duty there was one nurse and three care assistants. An activity therapist, catering, housekeeping, maintenance and administration staff were also available.

A staff training programme was on-going. All staff had up to date training in fire safety, safeguarding of vulnerable adults and manual handling. Training planned included management of responsive behaviour, nutritional care, refresher training in infection control, and dementia care. An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers were available for all registered nursing staff employed.

Daily allocation sheet for staff nurses and care assistant was in place and this tried to ensure continuity of care. Staff are kept informed on changes to residents' health status through handover meetings, care plans and daily diaries. Regular staff meetings took place. Topics discussed include documentation, audit outcomes, infection control and day to day running of the centre. There were no volunteers working in the centre at the time of inspection.

Staff files reviewed contained all the required documents as outlined in Schedule 2, which showed there was a comprehensive recruitment process. The deputy person in charge and care coordinator confirmed that there were no volunteers working in the centre and that all staff employed had Garda Síochána vetting in place.

**Judgment:**  
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:***

Mary McCann  
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 report<sup>1</sup>

<b>Centre name:</b>	Moy Ridge Nursing Home
<b>Centre ID:</b>	OSV-0000364
<b>Date of inspection:</b>	11 and 12 July 2017
<b>Date of response:</b>	25 August 2017

### 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 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

An annual review of the quality and safety of care delivered to residents was available, however there was poor evidence available of improvements brought about as a result of the monitoring review. No quality improvement plan was completed post this review.

#### 1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

A plan is now in place to carry out service improvements incorporating audit results and findings, residents and family meeting feedback and staff feedback to continue to ensure that the service is safe, appropriate, consistent and effectively monitored

**Proposed Timescale:** 01/09/2017

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

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

A notification of an allegation of abuse had been submitted to HIQA. HIQA had also received unsolicited information with regard to this incident. The inspector noted that staff had not been offered refresher training in adult protection post this incident. A robust structured safeguarding supervision and support plan had not been developed as per recommended in the further action required post the investigation by the investigation team.

**2. Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

Crisis Prevention and Intervention Training incorporating Recognising and Responding to Elder Abuse and Safeguarding Vulnerable adults has been offered and scheduled to all staff. 35 staff have already attended and further training will be offered in September for the remainder of staff. A robust structured safeguarding support plan including ongoing supervision and management oversight has been developed as per recommendations .

**Proposed Timescale:** 25/08/2017

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

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

An environmental risk register was also available. Where risks had been identified and control measures put in place these risk assessments were not regularly reviewed.

**3. Action Required:**

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

Environmental risk register reviewed annually. Environmental audit completed monthly and risk register updated if additional risks identified. Risk management continues to be reviewed 3 monthly during Auditing and will be dated.

**Proposed Timescale:** 01/09/2017

**Theme:**

Safe care and support

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

The procedures with regard to the recording of fire drills require review. The fire drill records did not record the scenario or type of simulated practice, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario or whether evacuation had taken place and if there were any impediments to safe evacuation. Consequently there was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required to ensure safe evacuation would be attainable if the need arose. Additionally there was no documentation to support that simulated fire drills had been completed with night staffing levels.

**4. Action Required:**

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Fire Policy reviewed - fire drill records now include, record of the scenario and type of simulated practice- Fire drill also include the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario and whether evacuation had taken place and if there were any impediments to safe evacuation. Any learning from fire drills will be clearly documented and any improvement/corrective actions will be identified to ensure safe evacuation. A schedule of fire drills is now in place and includes 4 fire drill be completed on the night shift

**Proposed Timescale:** 01/09/2017

## Outcome 10: Notification of Incidents

### Theme:

Safe care and support

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

The inspector found that the centre has failed to adhere to the legislative requirement to submit some notifications to the Chief Inspector within three days of the occurrence of the event. For example an NF06 notification with regard to an allegation of abuse which was reported to the person in charge on the 31 May 2017 was not received by HIQA until the 14 June 2017, an NF03 notification with regard to 'any serious injury to a resident that requires immediate medical and/or hospital treatment' which occurred on the 18 Jan 2017 was not received by HIQA until the 26 Jan 2017. There were other examples of notifications not been received with the statutory timescale.

### 5. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

All notifications will now be submitted to HIQA as per legislative requirements

Proposed Timescale: Immediate

### Proposed Timescale:

## Outcome 16: Residents' Rights, Dignity and Consultation

### Theme:

Person-centred care and support

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

Curtains in shared bedrooms did not protect the residents' privacy fully. While they divided the rooms, if a resident wished to use the en-suite facilities when the other resident was in bed they had to go through their private space.

### 6. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

A schedule for changing the curtains in the shared bedrooms is now in place for completion in 6 months.

