

# eDeposit Ireland

## Moorehall Lodge Drogheda, Dublin Road, Drogheda, Meath

Item Type	report
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Citation	Una Fitzgerald, 'Moorehall Lodge Drogheda, Dublin Road, Drogheda, Meath', [report], Health Information and Quality Authority, 2017-12-14, Older People Inspection Report, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-05-19 10:28:15
Link to Item	<a href="https://hdl.handle.net/20.500.14765/85613">https://hdl.handle.net/20.500.14765/85613</a>

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Moorehall Lodge Drogheda
<b>Centre ID:</b>	OSV-0000737
<b>Centre address:</b>	Dublin Road, Drogheda, Meath.
<b>Telephone number:</b>	041 981 8400
<b>Email address:</b>	sean.mccoy@mhliving.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Moorehall Healthcare (Drogheda) Limited
<b>Provider Nominee:</b>	Sean McCoy
<b>Lead inspector:</b>	Una Fitzgerald
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	106
<b>Number of vacancies on the date of inspection:</b>	2

## **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 1 day(s).

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

From: 03 October 2017 08:00 To: 03 October 2017 19:30

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	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	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 carried out to monitor ongoing regulatory compliance.

During the course of the inspection, the inspector met with residents and staff, the provider nominee, person in charge and the management team. The views of residents and staff were listened to, practices were observed and documentation was reviewed.

The inspector found that care was delivered to a high standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The management team responsible for the governance, operational management and administration of services and resources demonstrated good knowledge and an ability to meet regulatory requirements.

The management and staff were striving to continuously improve outcomes for residents. A person-centered approach to care was observed. Residents appeared well cared for and expressed satisfaction with the care they received. There was good evidence that independence was promoted and residents have autonomy and freedom of choice. Residents spoke positively about the staff who cared for them.

There was a total of 2 action plans required from the last inspection. Findings from this inspection highlight that significant progress had been made in addressing the non compliances identified in the last inspection and the centre is now judged as compliant in Outcome 9 Medication Management.

Overall, good compliance with the regulations was found during this inspection. The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.

**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):**

No actions were required from the previous inspection.

**Findings:**

There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure with explicit lines of authority and accountability, and the management team's roles and responsibilities for the provision of care are unambiguous. The management team facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions and was focused on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents.

A comprehensive auditing and review system was in place to capture statistical information in relation to resident quality outcomes, operational matters and staffing arrangements. Clinical audits were carried out that analysed falls management, medicine management, care plans and health and safety audits. This information was available for inspection. All audit results reviewed by the inspector had an action plan follow up attached to the findings. Policies and procedures were in place to guide practice and a review of Schedule 5 policies was in place.

The management support structure in place is comprehensive. The provider nominee and person in charge are actively involved in the running of the centre. There is a monthly risk management team meeting. An annual review of the quality and safety of care delivered to residents for 2016 was completed that informed the service plan being implemented in 2017.

The residents and relatives spoken to throughout the one day inspection were knowledgeable about who the Director of Care was and voiced that they would have no hesitation in bringing any issues to her attention. In addition the relatives voiced full confidence that any complaint made would be appropriately followed up.

**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 protect residents from being harmed or abused. The policy was implemented November 2016 and it provided guidance for staff on the various types of abuse, assessment, reporting and management of allegations or incidents of abuse. Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were put in place to ensure the safety and welfare of residents. The training matrix evidenced that in total there were four staff due training on Safeguarding and safety. The inspector was informed that these staff would be captured at the next schedule training date on the 12th October 2017.

The inspectors saw that measures had been taken to ensure that residents were protected and felt safe while at the same time had opportunities for maintaining independence. Communal areas in all households were accessible to residents. The inspector saw that there were facilities and equipment available to support residents to retain their independence. For example mobility aids, hand rails on corridors and circulating areas. There was a call bell facility in all rooms and within easy reach of residents. Residents told inspectors that they felt safe in the centre and spoke highly of the staff caring for them.

There was a system in place for the safeguarding of residents' finances and property. The provider was acting as a pension agent for one resident. An application to open a separate resident account was in progress and the management team were able to evidence same. Once finalised the monies will be held in a separate account.

The systems in place to promote a restraint free environment in line with the national policy was described and demonstrated. A restraint policy last updated in December 2016 was available. The centre had a record of all restraint currently in use on each household. Staff and records confirmed that in total five of the 105 residents were using

bedrails that restricted movement. The restraint policy clearly defined restraint and outlined the types of restraint, assessment, checks and review practices. There was evidence of alternatives available such as low beds, sensor alarms and crash mats. The inspector reviewed two files. A consent form was signed. The GP, registered nurse and next of kin all were involved in the decision. There was also clear evidence that a review is carried out on bedrail usage every four months. Records of the duration of restraint and safety checks or releases were recorded and evidenced by the electronic system in place.

The centre had a policy on and procedures in place to support staff with managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). This policy dated December 2016 was informed by evidence-based practice. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The inspector reviewed a care plan for a resident who had responsive behaviour. The care plan was person centered and identified potential triggers and guided the clinical team on how best to manage any incidents. The guidance and system in place had templates of Activating Event, Behaviour and Consequences (ABC) assessment charts for recording any incidents. The inspector found that ABC charts were consistently updated on the electronic system in place when incidents occurred and this information was utilized by the multidisciplinary team to guide interventions. Referrals were also made to specialist psychiatry of older life when required.

**Judgment:**

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):**

No actions were required from the previous inspection.

**Findings:**

The centre had policies and procedures relating to health and safety within the centre last reviewed in December 2016. There was a health and safety statement dated February 2017. The centre has a suite of risk management policies last reviewed in December 2016 that include the requirements set out in Regulation 26(1). The centre had a current risk registrar that is kept under constant review on a monthly basis by the management team. The register identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents.

Arrangements, consistent with the national guidelines and standards for the prevention

and control of healthcare associated infections, were in place. Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. Household staff spoken to were knowledgeable on the system in place to ensure that the cleaning regime minimises the risk of cross infection. The cleaning schedule included the routine daily chores but also contained detail of a deep cleaning schedule. The daily cleaning schedules in communal bathrooms were all signed off daily. Residents spoken too confirmed that their bedrooms are cleaned on a daily basis. The inspector observed that the standard of cleanliness throughout the building was of a high standard.

Suitable arrangements were in place in relation to promoting fire safety. Fire safety and response equipment was provided. Daily checks are carried out on all escape routes and there is a weekly fire alarm test. The fire alarm is serviced on a quarterly basis and the fire safety equipment is serviced on an annual basis. The fire fighting equipment annual servicing was underway during the inspection. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Staff spoken to were knowledgeable about fire safety and evacuation procedures. A detailed fire simulation fire drill was carried out in March and May 2017. There was clear evidence that any areas identified that required follow up were actioned and communicated to staff. The training matrix identified that of the current staffing compliment there were 33 staff due to have their annual fire training updated.

**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):**

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

**Findings:**

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Actions required from the last inspection had been carried out and the medication management policies were reviewed in September 2017. There were appropriate procedures for the delivery and collection by the pharmacy, and checking, storage, return and disposal of medicines by nurses.

Medications were dispensed to residents at a time of their choosing. Medications were dispensed from the clinical room in each household. Nursing staff were observed as they administered medications. Residents were unhurried and reminded of the purpose of the medicines administered. Prescription and administration records were maintained in

accordance with the centre's policy and professional standards. The processes in place for the handling and checking of medicines received including controlled drugs were examined.

Internal audits of medicines management was last carried out in July 2017. Medication errors were reviewed and learning from incidents and reported errors informed improvements to protect residents. All registered nurses carry out additional training in medication management. In addition, an external provider carries out medicines management audits to ensure compliancy with the regulations.

A system was in place for a regular prescription review by the resident's general practitioner (GP) and pharmacist.

**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:**

Residents' health care needs were met through timely access to medical services and appropriate treatment and therapies.

Access to a general practitioner and allied healthcare professionals including psychiatry of older life, physiotherapy, dietetic, speech and language therapy, dental, ophthalmology and specialist palliative care were made available when required. There was good evidence within the files that advice from allied healthcare professionals was acted on in a timely manner.

Pre-admission arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was maintained and shared between providers and services. On the discharge or transfer of a resident the electronic system in place had the capacity to provide a detailed discharge summary.

Assessments and clinical care accorded with evidence based practice. Residents had been assessed to identify their individual needs and choices. The assessment process used validated tools to assess each resident's dependency level, risk of malnutrition, falls risk and their skin integrity. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. The inspector reviewed the file of a resident with a wound. The care plan in place was detailed and guided practice. There was photographic evidence of healing. The clinical team had documented all relevant detail within the progress notes. The inspector also noted within an audit action plan dated February 2017 communication to all clinical staff on the risk associated with pressure sore development and on the management of pressure area care. Each resident had a comprehensive care plan developed with 48 hours of admission. The inspector noted numerous examples within each file reviewed that the care plans were person centered. The detail contained within the care plans evidenced that the staff were knowledgeable on the specific care needs of residents under their care. There was clear evidence that care plan reviews occur at intervals not exceeding four months or more frequently in consultation with either the resident or their representative. Both resident and relatives confirmed that they had spoken to nursing staff about their care plan.

**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):**

No actions were required from the previous inspection.

**Findings:**

The centre is divided into households and each household has a homemaker that remains in the kitchen and sitting area of each home throughout the day. Residents' views were welcomed and residents were consulted in relation to the running of the centre. A resident forum was last held in March 2017 and ten residents attended. The residents requested that activities be available seven days a week and this was actioned. Although not structured or minuted, the inspector was informed about an in house meeting titled 'learning circles'. This is a resident forum to discuss the entertainment and plan activities. The learning circle occurs 2-3 times weekly in each household and is chaired by the homemaker in each household.

Residents responded positively to staff interactions. Staff skillfully engaged and reminisced with residents using information they knew about their interests, families, friends and pets. Inspectors found that the atmosphere was warm and generally happy in the households. Significant taught has been put into each household to ensure that the atmosphere is welcoming and homely. For example, the staff do not wear clinical uniforms. Residents' bedrooms were personalised to a good standard with residents' input, such as their photographs, ornaments and other memorabilia that reflected their individual life stories. Some residents had items of furniture in their bedrooms that had been brought in from home.

Residents have access to an independent advocacy service. The centre is part of the local community and residents have access to radio, television, newspapers, information and frequent outings to local events. During the days of inspection the inspector observed multiple examples how the routines, practices and facilities maximize residents' independence. The activity programme within the centre offers a wide variety of options for all residents.

Overall, on the day of inspection there is evidence that residents have the opportunity to participate in group activities that are meaningful and purposeful that suits their individual needs and interests. The staff described one to one activities that occur for residents that do not wish to attend group activities. The inspector could not find evidence of one to one activities. The centre management informed the inspector that they had discussed this aspect of documentation and are in discussions on how best to manage capturing the one to one activities that are carried out.

**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:**

Inspectors reviewed actual and planned rosters for staff, and found that staffing levels

and skill mix were sufficient to meet the needs of residents. On-going weekly reviews of the care dependency levels of the residents is carried out by the person in charge that informs the staffing compliment required to ensure the delivery of high quality care. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities. The person in charge explained the systems in place to supervise staff. Recruitment and induction procedures were in place. Staff spoken with felt supported by the management team.

Evidence of current professional registration for all registered nurses was seen by the inspector.

The training matrix was reviewed by the inspector. In addition to mandatory training, the centre provides training in a range of areas including dementia care, falls prevention management and infection control practices. The training matrix that was available identified which staff had attended training and any gaps were highlighted. The management team had taken steps to address the gaps in current requirements.

All documents required under Schedule 2 of the regulations are contained in the personnel files. All staff files reviewed had Garda Vetting disclosures in place. The provider nominee confirmed that all current staff have completed a Garda vetting disclosure. There were no volunteers working within the centre.

**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:***

Una Fitzgerald  
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>	Moorehall Lodge Drogheda
<b>Centre ID:</b>	OSV-0000737
<b>Date of inspection:</b>	03/10/2017
<b>Date of response:</b>	24/10/2017

### 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 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:

The training matrix identified that of the current staffing compliment there were 33 staff due to have their annual fire training updated.

#### 1. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency

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

procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Those staff for whom fire training is due will attend training throughout October and November.

Proposed Timescale: 3rd October 2017 to 30th November 2017

**Proposed Timescale:** 30/11/2017

**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:**

The staff described one to one activities that occur for residents that do not wish to attend group activities. The inspector could not find evidence of one to one activities. The centre management informed the inspector that they had discussed this aspect of documentation and are in discussions on how best to manage capturing the one to one activities that are carried out.

**2. Action Required:**

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

We reviewed and adjusted our activity recording forms and as a result all one to one activities that occur for residents daily are now being recorded consistently.

**Proposed Timescale:** 19/10/2017