Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Moate Nursing Home
Centre ID:	0068
Centre address:	Dublin Road
	Moate
	County Westmeath
Telephone number:	090 6482855
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Email address:	moatenursinghome@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Mowlam Healthcare Ltd
Person in charge:	Nicola Daly
Date of inspection:	28 September 2011 and October 10 2011
Time inspection took place:	**Day 1: Start:** 09:30 hrs **Completion:** 18:00 hrs **Day 2: Start:** 11:50 **Completion:** 17:20
Lead inspector:	Catherine Connolly-Gargan
Support inspector:	Ann Delaney
Type of inspection:	**Day 1** ☒ Announced **Day 2** ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration, and meet the Standards that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Moate Nursing Home is a purpose-built, two-storey building, providing long term, convalescence and dementia care for up to 50 residents. Accommodation consists of 48 single bedrooms and one twin bedroom, all with en suite toilet and hand-washing facilities. There are five additional toilets, (four of which are wheelchair accessible), a dining area, day room, nurses' stations, and there is a visitors' toilets available on each floor. There are three assisted showers and one assisted bathroom for residents' use. The kitchen, laundry and offices are located on the ground floor. The designated smoking room, hairdressing salon and visitors' room are situated on the first floor. There is a lift and stairs between the ground and first floor.

Externally, there are landscaped gardens to the front and rear of the centre. An enclosed patio and garden area is at the rear of the building, which residents can access through the dining room.

Location

The centre is situated on the outskirts of Moate in county Westmeath. There are many local amenities within walking distance from the centre such as shops, restaurants, public houses, a library, a community hall and a hotel.

Date centre was first established:	25 June 2001
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	3

Dependency level of current residents	Max	High	Medium	Low
Number of residents	6	16	22	3

Management structure

The Providers are Mowlam Healthcare ltd and Patrick Shanahan, a director of the company, acts for and on behalf of the Provider. A Regional Operations Manager, Patricia Kelly, reports directly to the Provider. The Person in Charge, Nicola Daly, reports to the Regional Operations Manager and is supported in her role by staff nurses, one of which deputises in her absence, carers, catering, cleaning, maintenance and administration staff. All staff in the centre report directly to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	2	7	2	3	1	1x maintenance person 1x activity coordinator 1 x staff member completing audits

Background

Moate Nursing Home had six inspections to date and the provider has been met by the Authority on one occasion. Many of the same breaches are ongoing through the inspections. Such as supervision of staff, pressure area management, protection, medication management. There was also evidence where actions were satisfactorily addressed; this progress was not sustained in all areas. For example, pressure area management and fire safety.

The first inspection was a triggered unannounced inspection carried out on the 06 and 07 October 2009 in response to information received by the Authority relating to residents' pressure area care management and wound care. Inspectors had significant concerns due to findings in relation to pressure area care, prevention, intervention and management of pressure ulcers, which included staff training and education. Incomplete and insufficient assessment, planning, implementation and evaluation of residents needs were also of significant concern.

Other areas of significant concern were related to the completion of centre-specific policies, practices and records, medication management practices.

The second inspection of the centre occurred on the 05 March 2010 and was an unannounced follow-up inspection of the action plan developed from findings of the triggered inspection of the 06 and 07 October 2011. Three actions were not satisfactorily completed but were within the timescales agreed. From the actions completed inspectors were satisfied that there was evidence that learning had taken place from the previous inspection of 06 and 07 October 2009.

Education and training sessions on pressure area and wound care was provided for staff. Inspectors were satisfied that the incidence of pressure sores had decreased and that healing of existing sores was promoted in practice and evident in residents' records. The resident who had a grade three pressure sore on the 06 October 2009

had protective measures and preventive equipment in place and the sore had healed completely.

Assessment, planning, implementation and evaluation of residents needs had improved as had communication systems and practices.

The third inspection (Registration) was an announced registration inspection carried out on 07 and 08 July 2010 and inspectors found that overall Moate Nursing home provided a fair standard of care. While there were a number of good practices as part of the registration inspection process, inspectors reviewed pressure area care and management. A resident referenced in a follow up inspection on March 5 2010 with a grade two sore on the ankle had reduced to a grade one. This resident was readmitted from hospital on July 7 2010. The person in charge told inspectors that this ankle wound had deteriorated during his hospitalisation to a grade four sore. Although all staff was not trained in pressure area care management and all staff were not informed in the report of this event in the staff handover, the management plan put in place was of a good standard. There were no other residents with pressure related skin damage.

The inspectors also found other aspects of the service that needed improvement. Improved staffing levels were required to ensure the needs of all residents are met. An accountable system to indicate ownership of residents' clothing was required. There was a need for additional staff training to meet the needs of the current residents in the area of end of life and care of residents with dementia. Twenty actions were identified from findings during this inspection.

The fourth inspection was an announced follow-up inspection carried out on the 25, 28 January 2011 and on February 14 2011 to follow up on the actions from the registration inspection. The providers fit person interview was also completed. Inspectors found that seven out of twenty actions referenced in the Action Plan had been satisfactorily completed. The remaining thirteen actions (one of which was still within the timescale agreed) were partially completed to varying degrees by the provider/person in charge to bring the centre into full compliance with the legislation and standards. Twelve of these uncompleted actions were outside of the timescale agreed. Eight actions were the responsibility of the provider while the person in charge had legislative responsibility for four actions.

Inspectors confirmed that there was a comprehensive pressure area management (PAM) system was in place. However, residents residing in the centre continued to develop grade two pressure ulcers and on 14 February 2011, an inspector returned to the centre to evaluate the standard of pressure area management and review documented incidents of skin tear injuries to residents sustained during care procedures.

Review confirmed that all recommended procedures documented in the policy were not adhered to at all times. Documentation which referenced the care given was missing. Progress reports documented by staff nurses required improvement to ensure communication on all aspects of care between staff. Evidence-based interventions were not in place for residents who were assessed as 'at risk'. Four residents

developed skin breakdown. While treatment procedures were adequate in most respects, prevention procedures were of a poor standard.

Fire safety management was partially completed with adequate arrangements for checking of emergency exits outstanding. Documentation requesting certification of full fire safety compliance had been completed and received by the Authority. Risk management procedures were not satisfactory, as unaccompanied vulnerable residents continued to be at risk on the back stairs.

Inspectors' findings confirmed that supervision of all grades of staff was not adequate. The standard of cleaning and maintenance required significant improvement. Inspectors found that equipment was visibly soiled and placed residents at risk of cross-infection.

Supervision of care staff to adequately and safely meet residents' needs remained poor. For example, residents were put at risk of injury due to unsatisfactory moving and handling procedures. Staff continued to fail to carry out moving and handling practice outlined in residents' manual handling assessments and care plans. Although training had been given to staff, their practice did not meet evidence-based standards.

While the person in charge discussed how she was reviewing communication aides for residents with cognitive disabilities, the inspector noted that the fulfilment needs of all residents' were not met, particularly those with cognitive impairment.

Work had been done by the PIC to make improvements in the area of anticoagulant medication management practices.

The fifth Inspection was an unannounced follow-up inspection. There were thirteen actions in the action plan developed as a result of inspectors' findings at the follow-up inspection dated 25 and 28 January and 14 February 2011. This inspection found evidence that three of these actions were satisfactorily completed. Eight were partially completed to varying degrees and two were not satisfactorily. However, one action and one sub action were still within the times scale for completion agreed. The actions not satisfactorily completed included wafarin medication procedures and preventative pressure area care.

Inspectors found that while some improvements had been made significant issues remained, for example appropriate supervision and support for staff providing care, staff training, recruitment procedures and preventative pressure area care management. All measures to ensure resident protection from harm and abuse were not in place. The person in charge could not assure inspectors that agency staff had training on the prevention, detection and management of elder abuse training. New areas requiring improvement to meet the requirements of the legislation included transcription of medication practices and some aspects of governance.

Progress had been made in some areas. For example, residents were provided with a good choice of nutritious diet. The centre was visibly cleaner and there were procedures in place to improve cleaning standards on an ongoing basis. A communication sheet was introduced to improve the consistency of care.

Meeting on the 27 April 2011 – The Authority met with the provider and pperation manager to discuss on-going areas of ongoing breaches in the regulations.

Summary of findings from this inspection

This sixth Inspection by the Authority was a two day inspection, announced on the 28 September 2011 and unannounced on the 10 October 2011. This follow-up inspection was to assess progress with meeting the requirements set out in the action plan of the follow-up inspection on the 30 March 2011.

The Authority also carried out a fit-person interview with the newly appointed person in charge. Nicola Daly commenced in the role on 08 August 2011. There were 11 actions in the action plan. One action was on addressing Schedule 2 documentation for staff which was satisfactorily completed. The remaining ten actions were partially completed to varying degrees and were on-going from previous inspections.

Residents' recreational needs were met to an improved standard as was their communication needs. Dietetic services were available to residents in the centre and a review of catering had taken place with the assistance of the dietician.

The management structure in the centre was weakened as a senior nursing post was vacant. Protection of residents was not of an adequate standard. Not all staff were able to appropriately articulate how they would respond to an allegation of elder abuse. An allegation of elder abuse by a staff member reported to the Authority was substantiated and addressed to protect residents.

Quality review and management of clinical risk was in place but required more development. Staff supervision was not of a good standard and required significant improvement. Residents continued to develop pressure related skin ulcers and injuries related to care procedures.

Medication management procedures related to prescription and administration also required improvement. There were errors with medication documented which were not fully investigated. A new medication management system was recently introduced into the centre to assist with improving practices and was being evaluated.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Actions reviewed on inspection:

1 Actions required since last inspection:
Review the staffing levels on day and night duty, taking into account the size and layout of the centre, the number of residents, their dependencies, and their assessed needs and ensure that all residents' needs are met.

Put arrangements in place to ensure that there is adequate staff available to supervise vulnerable residents at all times.

Revise the current staffing arrangements for the laundry.

This action was partially completed.

A decision was taken following review of the staffing levels and skill mix to roster an additional registered nurse on night duty. As a result, the minimum standards for staffing levels on night time are two registered nurses and two carers. While this standard was not always maintained the person in charge stated that she had put procedures in place to ensure that two staff nurses were rostered on every night duty. A review of a copy of the staff nurse duty roster from the 03 to the 16 October 2011 supported this statement.

An arrangement was facilitated where residents were facilitated to rest in the sitting room on the first floor as well as the sitting room on the ground floor. This initiative was to give residents choice and to also utilise the facilities to their potential facilitating more communal space for each resident. However, inspectors noted that the sitting room on the first floor was not adequately supervised at all times. Call bells were ringing for prolonged periods without being answered.

The Authority was informed that a Clinical Nurse Manager was commencing employment on 05 July 2011. A key responsibility of this role was to carry out supervision of practice and clinical training of staff. Although the person commenced in the centre, all professional records were not in place for the candidate and inspectors were told that she carried out auditing and other non-nursing duties from appointment up to 06 October 2011.

The laundry service is now staffed from 09:00 hrs to 16:00 hrs, seven days per week.

2. Actions required since last inspection:
Put in place a system for supervision and support to the Person in Charge.

This action was partially completed.

A quality manager had been assigned to fill the role of person in charge on an interim from 16 May 2011 and to mentor and supervise the newly appointed person in charge from the 08 August 2011 to 31 August 2011 which was completed.

The role also included mentoring and supervision of the clinical staff in the home. This support was an interim arrangement. Going forward the person in charge is met on a weekly basis by the operations manager who is also accessible by mobile phone.

There was also evidence that support was increased recently by a quality assurance manager and the operations manager.

However, at a local day to day level, there was an absence of senior staff to support the person in charge in her role. Inspectors were not satisfied that the recently appointed person in charge had adequate local support in place due to a vacant clinical nurse manager post and no suitably experienced nurse to deputise in her absence. The person who deputised in her absence was also recently appointed in the centre. There was evidence that due to this lack of senior local support, not all aspects of the governance, operational management and administration responsibilities of her role were adequately fulfilled. Documentation was not completed and forwarded to the Authority informing of the change of person in charge as required.

3. Actions required since last inspection:

Put procedures in place to where the person in charge ensures that all persons with access to residents are appropriately vetted in line with the legislation.

The activities program in the centre requires development so that residents with physical, cognitive or sensory disability are afforded ample opportunity for participation in purposeful and meaningful activity.

Make arrangements that the programme of activity is informed by each resident's previous routines, hobbies and interests, and their social and cultural background; it is reviewed with the residents on a regular basis and there is clear evidence of this.

Ensure that the programme of activities is clearly displayed for residents in a suitable format.

Audit the staffing provided for the activity programme to ensure that is sufficient to meet the assessed needs of the current residents'.

This action was partially completed.

A seven-day activity programme has been put in place, activity coordinator hours have been increased to cover each day from 10:00 hrs to 21:00 hrs. Social assessments were completed for all residents in the home and these assessments identify the occupations and interests of the residents prior to their admission to the centre.

The recreational programme has been revised to be more reflective of residents' interests. As a result of feedback from assessments, some residents participate in

baking. A chicken coop has been installed with chickens. Although, not readily accessible to vulnerable residents due to its location at the back of a lawn. A plan was in place to lay a pathway through the garden. Newspaper readings, a fit for life programme among a variety of other activities were scheduled throughout each day. This weekly schedule was displayed which facilitated resident a choice to participate if they wished.

Residents were noted by inspectors to be engaged and interested in the activities provided in the ground floor sitting room. Feedback from some cognitive impaired residents to inspectors was that they found the day long and looked forward to relatives and friends visits. Residents with conditions that impaired their cognitive function or residents who were not well enough to leave their rooms required a divertional therapy programme. However, the person in charge told inspectors that this area was going to undergo ongoing development to a standard where all residents' recreational needs were met to a good standard.

Volunteers did not attend the centre. However, the person in charge had procedures in place to ensure when this area is developed again that all volunteers would be appropriately vetted.

4. Action required from previous inspection:

Put procedures in place to develop the skills and knowledge of staff involved in supervising others.

Put robust procedures in place where all grades of staff are supervised on an appropriate basis pertinent to their role.

Provide staff with access to training to develop the understanding and skills required to care for residents with a diagnosis of dementia.

Ensure that all staff receive training in, and are familiar with and implement all policies and procedures within the designated centre to guide and inform a high standard of evidence–based nursing practice.

Review the effectiveness of training delivered to staff and assess competency of all staff to ensure training is reflected in practice.

This action was partially completed.

The post of clinical nurse manager in the centre was vacated since the follow-up inspection of 30 March 2011; this has not been successfully filled to date. There was evidence that supervision of all grades of staff was not of an adequate standard. However, the lack of adequate supervision for nursing and care staff was of significant concern due to adverse outcomes to the care and welfare of some residents in the centre. These adverse outcomes included medication errors, injuries sustained during care procedures and unwitnessed resident falls, some resulting in a serious injuries and pressure related skin breakdown.

Although all staff had job descriptions detailing their roles and responsibilities, the person in charge and the operational manager told the inspector that they were in the process of developing a schedule of tasks that each grade was responsible for to reinforce the detail of roles and responsibilities in their job descriptions.

Training of staff to increase awareness and knowledge of caring for residents with a diagnosis of dementia has been commenced. This was reinforced by staff access to learning via DVD to gain a greater understanding of care of residents with dementia and to consolidate training to date in this area.

The person in charge was part way through meeting all staff on a one-to-one or one-to-two basis to monitor the effectiveness of training delivered to date in the high risk area of elder abuse recognition, prevention and whistle blowing procedures and to assess staff competency through conversation and assessment of knowledge in these areas.

While a comprehensive record of staff training was copied to inspectors, not all staff had completed mandatory training in safe lifting and handling procedures. While inspectors identified no deficit in staff practices observed on this inspection, ongoing incidents of resident skin tears were logged.

Although the person in charge stated that she will undertake a systematic process of increasing awareness and knowledge of all staff regarding all policies and procedures within the home. She had commenced with elder abuse recognition, prevention and whistle blowing but this area required significant improvement.

5. Action required from previous inspection

Put procedures in place to ensure residents at risk of deteriorating nutritional health are referred to the dietetic services for review. Implement recommendations from this review.

Develop and implement a comprehensive preventative management program for residents at risk of developing pressure ulcers.

Ensure residents at risk of skin breakdown have a comprehensive person centred care plan in place.

This action was partially completed.

Residents at risk of deteriorating nutritional health are now referred to the dietetic service where appropriate and/or necessary. A dietician attends the centre and reviews residents referred. An information folder on nutrition has been developed and is available for reference by staff. The dietician gave a presentation on fortifying foods for residents who required same to support their nutritional intake. A dining audit was completed by the dietician and the results were copied to the catering staff. Home made soups are provided for residents.

All residents have an up to date Waterlow assessment. Although there was a comprehensive preventative program on pressure related skin damage in place, a resident's skin had broken down and a grade two sore was in place on the days of inspection. However, although plans were in place for robust clinical supervision and heightened awareness among all staff, including care assistants for management of residents at risk of developing pressure ulcers. Pressure related skin breakdown was still occurring.

A comprehensive person-centred care plan was in place for those residents identified as being at risk of skin breakdown and appropiate treatments were in place. There was evidence that the centres wound prevention procedures still required improvement. One resident had a grade two pressure related skin wound on the day of inspection which occurred in the centre. The centres wound management programme was in place and was effective in that the wound was healing

6. Actions required from previous inspection:
Revise the medication management policy to include all aspects of medication prescribing, storage and administration.

Ensure that there are appropriate and suitable practices relating to the prescribing, storage and administration of anticoagulant medications to residents.

Put arrangements in place that prescriptions for controlled drugs are handwritten in entirety by the prescriber as in Misuse of Drugs Health Act, 2007 1977 and 1984.

Ensure by providing education and any other means that all medication practices and procedures are complaint with current legislation and An Bord Altranais Guidelines**.**

This action was not satisfactorily completed.

The medication management policy was reviewed and amended to reflect the limits and controls on nurse transcribing in accordance with the An Board Altranais ABA best practice guidelines. Although not yet documented that the new person in charge had authorised this document, it was introduced into practice on the 05 June 2011. While a transcription prescribing error occurred on the 08 August 2011, transcription of medication practices continues in the centre.

The provider stated in his response to this action plan on medication management practices around controlled medication prescribing that 'all prescriptions for controlled medications were handwritten in their entirety by the GP'.

However, the inspector noted that a controlled medication under the Misuse of Drugs Act, 1977 was transcribed on a resident's prescription and not signed by a doctor or transcribing nurse. The inspector also noted that in other cases a second nurse did not sign transcribed medications and the GP did not confirm discontinuation of medications by a signature.

Photographs have been added to the anticoagulant booklets as well as the prescription charts to aid identification of residents who were prescribed for this high alert medication. There were two residents on anticoagulation medications; one resident's anticoagulation therapy was discontinued on the second day of inspection following review by a GP.

However, staff in the centre continue to receive verbal results of residents' blood clotting times from the hospital laboratory which they then fax to the GP surgery. The GP then advises staff on the amount of the anticoagulant medication to be given based on the clotting time results received. Although no errors were documented as occurring with this arrangement, there was no evidence that the practice was audited or that risks were evaluated with controls put in place to minimise possibility of occurrence.

There were three documented incidents of medication error since the beginning of the year where residents received unprescribed medications. Following a review, a new medication dispensing system was introduced with supporting training for staff. A quality assurance process was in place where medications were checked on arrival to the centre and again prior to administration. A comprehensive medication near miss recording system was in place which captured any variances noted. Staff reported to inspectors that they were satisfied with the new system. As a result of a review of medication dispensing practice, the risk of the dispensing nurse being interrupted was identified. To mitigate this happening, a decision had been made to introduce the wearing of a red apron by the nurse dispensing medications. The purpose of this will be to deflect disturbances.

While all nurses had completed training on medication management, a plan was in place that all nurses would also complete the e-learning training programme 'A Guide to Medication Management' on the ABA website by the 1st September 2011. While the inspector noted that this was completed by only two staff, remaining staff were scheduled to complete this.

A medication competency programme led by the person in charge was being rolled out. The pharmacist visited the centre regularly and had been there on the week of the inspection.

7. Actions required from last inspection:

Provide adequate sluicing facilities.

Ensure that all areas of the centre are kept clean and suitably decorated.

Provide suitable storage area for assistive equipment and cleaning trolley

This action was partially completed.

Inspectors viewed both sluice rooms which were located one on each floor and noted each had a sluicing unit facility. However, the sluice on the ground floor was inaccessible due to a cleaner's trolley and other equipment stored in it.

An open top bin was filled with used mop clothes and an open bag hanging on the cleaners' trolley also contained used mops.

Two residents had potentially communicable infections – alginate bags were available and used for soiled laundry. The person in charge had been in contact with the infection control specialist regarding these cases. However, inspectors were not satisfied that there was adequate hand cleansing equipment in the centre. Some hand gels were hanging on handrails and hand gels were not available on exiting rooms where residents with potentially communicable infections were accommodated. Staff were noted to wash their hands in residents' en suite facility.

Inspectors were told that a deep clean of the home has taken place, and a redecorating programme was in place. Although corridors were in good repair, some walls in some residents' rooms and en suites were damaged and therefore could not be adequately cleaned. A room painting programme was in place and residents had decided on one of the three options available for their rooms.

Storage of residents' equipment remained of an inadequate standard and inspectors noted that this equipment also posed risk of injury to residents. For example, hoists were stored on corridors and protruded out into residents walking space posing a trip risk to vulnerable residents. The hairdressing room had been located to another part of the first floor, inspectors noted that two hairdryers were moved out onto the corridor to create additional space in the room but blocked the fire exit. Doors to bedrooms were wedged open with wooden pegs putting residents at risk in the event of fire as the doors open offered no protection. Equipment stored on corridors also rendered the hand rail in these areas inaccessible to residents

Inspectors also noted that wicker type seating on garden chairs was broken and not of a safe standard. Inspectors noted a resident seated on one of these chairs during the day of inspection.

8. Actions required from previous inspection:

Evaluate the lay-out and arrangements in the centre to ensure that it is specific to its stated function and purpose and adheres to evidence based principles for residents with dementia or cognitive disabilities.

Put in place appropriate signage and other communication and reality orientation aids for residents to assist mobility and orientation.

This action was partially completed

A consultation exercise regarding the needs of residents with cognitive impairment had commenced involving the residents, relatives and the activities coordinator. The aim of this being to provide assistive communication aids to residents. There was a plan to implement aids already in place such as talking mats into communicating with residents with needs in this area. Training on the use of the mats and other tools was in progress. A care plan was in place for residents with additional communication needs

Additional signage and cues for residents were located throughout the centre; each resident's door had a cue to a significant event or characteristic about them. Residents worked with the staff in selecting these. Two residents told inspectors the story behind the picture on their door.

Inspectors spoke with the person in charge in relation to the suitability of the layout of some of the rooms in meeting the needs of residents. For example, one resident with a lot of assistive equipment did not have space for it in her room and as a result it was stored on the corridor and not within ready access to her. Due to the nature of her condition she required assistance with turning in bed and personal care. Her bed was against the wall and needed to be pulled out to carry out care making the room inaccessible. Inspectors noted other residents who had maximum dependency needs also had their beds resting against a wall which necessitated moving the bed to provide care.

9. Action required from last inspection:
Put adequate procedures and staff training in place to ensure that all residents receive a high standard of physical, emotional and psychological care and comfort to meet their end of life needs.

This action was partially completed.

Two staff nurses had completed training in end of life care. A plan was in place for rolling this training out to other staff. There was one resident in receipt of palliative care on the days of the inspection and an end of life care plan was viewed for this resident. However, end of life wishes were not documented and staff were not aware of the arrangements for the end of this resident's life. Inspectors were told that the community palliative care team attend the centre when a resident with palliative care needs is referred to them. This team work in conjunction with the residents' GP. Inspectors viewed a pain assessment tool which was in use for all residents with needs related to pain. The GP was managing pain relief for the resident with palliative care needs as he was not referred for care by the community palliative care services.

While residents have access to a quiet room, the new person in charge told inspectors that she was in the process of identifying a suitable area for refurbishment as an oratory. In response to residents' feedback she had arranged for twice weekly Mass for those residents who wished to attend.

10 Action required from previous inspection:
Develop a process where audits carried out are analysed as a means of reviewing the quality of life and safety of care provided for residents in the centre at appropriate intervals.

This action was partially completed.

A system was in place for completion of eight audits which referenced environment, healthcare, home management and human resources. The data collated is sent to the provider where it is analysed. This information from analysis is shared with the centre staff and is used for governing the service. Some local audits had been done but audits and analysis of high risk areas such as medication management including medication errors and near misses were not yet adequately addressed.

Actions required from previous inspection:
Revise risk management policy to cover all aspects of Regulation 31 of the Care and Welfare of Residents in Designated centres for Older people) Regulations 2009 (as amended).

Facilitate training in moving and handling for all staff in the centre.

Complete an audit of all accidents/incidents to determine any causative factors or trends. Implement recommendations from this audit.

This action was partially completed.

While a small number of recently recruited staff did not have moving and handling training completed, inspectors noted that moving and handling procedures were of an adequate standard. However, residents continued to sustain injuries during moving and handling procedures.

Falls management required more analysis to elicit learning and appropiate proactive preventative actions that could be taken to prevent serious injuries occurring. For example, a resident who became restless and had also fallen on two previous occasions sustained a serious injury from a third fall which could have potentially been prevented if a full analysis of her history had been done.

The risk management policy did not cover all aspects of Regulation 31 of the Care and Welfare of Residents in Designated centres for Older people) Regulations 2009 (as amended).

12 Action required from previous inspection:
Put in place procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in schedule 2 have been obtained in respect of each person.

This action was satisfactorily completed.

Procedures are in place to ensure that all persons with access to residents were appropriately vetted in line with the legislation. Inspectors viewed six staff files and found that An Garda Síochána vetting was present in all cases. Volunteers no longer attend the centre. However, the new person in charge explained how she would ensure that those who come to the centre in the future are appropriately vetted.

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service

Standard	Best practice recommendations
Standard 12: Health Promotion	Residents with diabetes and constipation did not have education provided for them to promote their independence and capacity to make informed decisions about the food they eat to maintain their good health. **Provider Response:** A health promotion and information stand will be sourced for the reception area and will include information on a wide range of health information for residents. **Inspection Findings** Inspectors noted a health promotion stand with useful literature. The diabetic nurse had educated the residents with diabetes and also provided staff with information on caring for these residents. A daily communication sheet is completed by the registered nurse on night duty which informs catering staff on residents' dietary needs.
Standard 26: Health and Safety	Staff were not provided with sufficient computer terminals to input resident data easily. **Provider Response:** Computer terminal capacity will be reviewed. **Inspection Findings** Access to computer terminals was assessed. Staff had access to five terminals. A review to ensure the adequacy of this number was not completed.
Standard 24: Training and Supervision	Staff training records were not up to date. **Provider Response:** Staff training records are now up to date. **Inspection Findings** Inspectors were provided with training records for all staff which were up to date. There was also a process for ensuring that an up to date record was maintained.

Standard 15: Medication Monitoring and Review	Not all residents have a medication review by his /her medical practitioner at least on a three monthly basis. **Providers Response:** The person in charge will ensure that all residents have a review of medication on a three monthly basis. **Inspection Findings** A review of a sample of residents' medical records confirmed that residents had a medication review approximately on a three month basis.
Standard 2: Consultation and Participation	Feedback is not actively sought from the residents on an ongoing basis on the services provided for example residents were not consulted on the colour of paint for their individual rooms. **Providers Response:** Residents' preferences will be sought on aspects of the redecoration programme. **Inspection Findings** The person in charge told inspectors that residents would be given a choice of three shades of paint for their rooms going forward. Residents were consulted regarding the installation of a chicken coop. Inspectors were told that a path would be laid to make this area more accessible for residents.

Report compiled by:

Catherine Connolly-Gargan
Inspector of Social Services
Health Information and Quality Authority

28 September 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
06 and 07 October 2009	☐ Registration ☐ Scheduled ☐ Follow up inspection ☒ Triggered ☐ Announced ☒ Unannounced
05 March 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced
07 and 08 July 2010	☒ Registration ☐ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
25, 28 January 2011 and 14 Feb 2011	☐ Registration ☐ Scheduled ☒ Follow up inspection ☒ Announced ☒ Unannounced
30 March 2011	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced
27 April 2011	☐ Registration ☐ Scheduled ☐ Follow up inspection ☒ Meeting ☐ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report *

Centre:	Moate Nursing Home
Centre ID:	0068
Date of inspection:	28 September and 10 October 2011
Date of response:	03 November 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The person in charge has failed to comply with a regulatory requirement in the following respect:
Did not ensure that staffing levels and skill mix were appropriate to meet the assessed care, welfare and safety needs of all residents.

Action required:
Review the staffing levels on day and night duty, taking into account the size and layout of the centre, the number of residents, their dependencies, and their assessed needs and ensure that all residents' needs are met.

Action required:
Put arrangements in place to ensure that there is adequate staff available to supervise vulnerable residents at all times.

Reference:
Health Act, 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications

* 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 with timescales:	Timescale:
Provider's response: Staffing levels have been reviewed on day and night duty. A lecturer/practitioner has undertaken an observational study of the working practices within Moate nursing home, in order to assist the person in charge (PIC) to ensure that staff appropriate numbers and skill mix of staff are in place, and that care is planned and structured appropriately. There are now two staff nurses and two care assistants on night duty as evidenced by the staff rosters which are submitted to the Health Information and Quality Authority (the Authority) as part of the ongoing weekly monitoring report. There is a process in place to recruit a new clinical nurse manager to fill the vacant position. There is greater supervision of vulnerable residents; regular observation and assistance is provided to residents who wish to remain in their rooms; residents may also choose to visit the dayrooms, where there are group and individual activities. A member of staff is allocated to supervise the dayroom on each floor, and the Activities Coordinator spends a considerable time in the dayroom, so assistance is always readily available.	Completed Ongoing

2. The person in charge has failed to comply with a regulatory requirement in the following respect: All grades of staff were not adequately supervised when delivering care pertinent to their role.	
Action required: Supervise all staff members on an appropriate basis pertinent to their role.	
Action required: Provide a high standard of evidence based nursing practice in relation to prevention of pressure related skin breakdown and moving and handling of residents	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 17: Training and Staff Development Standard 18: Routines and Expectations Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response:	
The director of nursing has enlisted the support of a lecturer/practitioner who is currently working part-time in Moate nursing home. In addition to providing clinical support to the PIC until the vacant clinical nurse manager position has been filled, she has undertaken an observational study of working practices in the home, in order to reinforce and reiterate the need to ensure the care delivered is evidence-based. She is also providing in-service training to staff groups and individuals on how to plan and structure their day, keeping the needs and choices of residents at the centre of their practice. The lecturer/practitioner provides supervision herself, and also ensures that the allocation and supervision of staff is appropriately coordinated. She is working with staff nurses to help them to continue these practices in her absence, to ensure a consistent approach to care.	Observation study completed feedback to staff on 4 November 2011 In-service training has commenced and second care plan training on 10 November 2011 and ongoing
The PIC has met with all staff to discuss their roles and responsibilities.	Completed
Further training is being arranged for specific staff to ensure that they are appropriately skilled to meet the needs of residents, eg. venepuncture training for staff nurses.	First in service will take place 14 November 2011
In addition, the physiotherapist will also provide specific training on the positioning and mobilisation of specific residents. In this way, the training provided to all staff on manual handling will be translated to practice, and this will also encourage all staff to employ the correct techniques at all times.	First training will commence 10 November 2011 and ongoing

3. The provider and person in charge has failed to comply with a regulatory requirement in the following respect:

Not all residents with conditions affecting their cognitive or sensory well-being had opportunities to participate in activities appropriate to their interests and capacities.

Action required:
Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Reference:
Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 18: Routines and Expectations

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

Provider's response:	
There are two activities coordinators employed in Moate nursing home, and they have both received training in the provision of activities for residents with cognitive impairment and/or a diagnosis of dementia, such as Sonas sessions and reminiscence therapy. Greater efforts are now being made to ensure that the Activities Coordinators engage with residents who choose to remain in their rooms as well as residents who wish to participate in group activities.	Ongoing December 31 2011
The interests and previous occupations and hobbies of residents are reflected in the social assessments on the electronic documentation record. Life stories of residents i.e. are record of interests, occupations, stories from their lives, memories and mementoes are captured and recorded in consultation with the resident and/or their family.	The process will commence on 21 November 2011

4. The provider has failed to comply with a regulatory requirement in the following respect:
Did not ensure that all medication practices and procedures were complaint with current legislation and professional guidelines

Transcription of residents' medications did not meet professional standards.

Action required:
Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference:
Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management
Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The practice is only undertaken by the director of nursing and counter-signed by another staff nurse, designated by the director of nursing. No transcribing will take place in the absence of the director of nursing. The operations manager and PIC have agreed to meet with GPs in order to discuss that the processes related to prescribing, ordering and administration of medicines are in line	Ongoing Meetings to be scheduled

with national regulations including the Authority's standards and An Board Altranais guidelines, and in so doing to reduce the risk of error in relation to medication management.	
There are written policies in place relating to the ordering, prescription, storing and administration of medicines. To greater safety of the resident, a second registered nurse will accept the INR result over the telephone and co-sign the faxed sheet to the G.P.	Completed
The PIC has commenced medication competency assessments for all staff nurses, in relation to medication management and has assessed 2 staff nurses to date. She will continue these assessments until all staff nurses have been assessed in relation to medication management.	December 31 2011
The PIC has arranged for all staff nurses to log on to the e-learning medication programme on the ABA website and will monitor their progress on this course. All staff nurses have been encouraged to complete this course by the end of December 2011.	December 31 2011

5. The provider has failed to comply with a regulatory requirement in the following respect:

All areas of the centre were not clean or adequately maintained.

There was inadequate storage space for assistive equipment and cleaning trolley.

The sluice was inaccessible.

Patio chairs for use by residents were not maintained in a safe condition.

The layout or size of rooms occupied or used by residents were not all suitable for their needs.

Action required:

Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

Action required:

Ensure that all areas of the centre are kept clean and suitably decorated.

Action required:

Ensure the premises are of sound construction and kept in a good state of repair externally and internally

Action required:

Maintain the equipment for use by residents or people who work at the designated

centre in good working order.
Action required: Provide necessary sluicing facilities.
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Mowlam facilities director has completed a facilities audit of the centre from which will be developed a refurbishment and re decoration programme. This will include review of all space. Both sluice rooms are accessible, in use and staff have been educated on the importance of the use of sluice rooms for prevention of cross-infection and the need for greater hygiene in the home. Full assessment of garden furniture carried out and unsafe garden furniture removed from centre.	 Ongoing Completed Completed

6. The provider has failed to comply with a regulatory requirement in the following respect: Residents did not have access to handrails in some parts of the centre. Not all staff had safe moving and handling training Did not adequately investigate all incidents of medication errors to identify learning.
Action required: Provide handrails in circulation areas.
Action required: Provide training for staff in the moving and handling of residents.
Action required: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A review of all space is under way and efforts are been made to relocate linen and laundry skips off the corridors so that handrails are accessible throughout the home. The storage of hoists have been located. All staff have completed moving and handling training. In addition, the physiotherapist will be undertaking practical training with staff regarding specific mobilisation, transfer and positioning techniques to be used with individual residents. A formal clinical governance committee has been scheduled to take place on 15 November 2011 at which a full review of incidents and adverse events will be undertaken and discussed with staff. This will ensure that all incidences are fully investigated and reported appropriately, and that findings/actions/outcomes are communicated to appropriate staff groups in order that learning can take place. Meanwhile informal reviews of incidents and adverse events are taking place on a regular basis.	 Ongoing Ongoing November 30 2011

7. The person in charge has failed to comply with a regulatory requirement in the following respect:
Did not ascertain residents' end of life wishes.

Action required:
Identify and facilitate each resident's choice as to the place of death, including the option of a single room or returning home.

Reference:
Health Act, 2007
Regulation 14: End of Life Care
Standard 16: End of Life Care

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Two staff nurses recently attended a course on end of life care. The Lecturer/Practitioner has commenced in-service training on end of life care and care planning, including how to involve residents and relatives in planning end of life care and incorporating residents' wishes.	 Completed Commenced and ongoing

8. The provider has failed to comply with a regulatory requirement in the following respect: Information collated in audits was not analysed to identify trends, learning and to improve the quality of life and safe for residents.	
Action required: Establish and maintain a system in the centre for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals	
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The quality and governance manager has scheduled a project with the Person-in-Charge to ensure that the audit cycle is completed, i.e. that audits are undertaken on a regular basis, and that the audit outcomes are supported by action plans which are documented, achievable and measurable within reasonable timeframes. The audit outcomes and action plans will be made available and visible for all staff to read, and active discussions will take place in team briefings, by way of handovers and staff meetings so that there is a heightened awareness among staff about the role, purpose and function of audits as a quality improvement tool.	Commenced and ongoing
The care assessments for each resident is regularly updated so that nurses and care staff deliver in practice the care needs identified through the assessment process. The lecture practioner will assist staff in involving residents and relatives in care planning and perceived care needs. Greater care is now being taken to document residents' and families' wishes. Training sessions on care planning are under way by the lecturer/practitioner.	January 2012
An annual survey/questionnaire is currently under development which will be sent to all residents and some family members; this will help inform the PIC about the quality of life, care and the overall satisfaction and comfort of residents in Moate nursing home.	January 2012

9. The provider has failed to comply with a regulatory requirement in the following respect: Doors to residents' rooms were wedged open.	
Action required: Make adequate arrangements for detecting, containing and extinguishing fires.	
Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Door wedges have been removed. The staff have been reminded to check this on a daily basis to ensure compliance. Regular fire safety checks are carried out. Fire wardens are readily identifiable: the staff nurse in charge on each floor is the fire warden. When the kitchen is open, the chef on duty is also a fire warden. Mandatory fire training updates have been arranged for all staff.	 Completed Completed and Ongoing Completed November 17 2011

Any comments the provider may wish to make:

Provider's response:

The centre is pleased that the report recognises the progress made by the team in the centre. The outstanding actions raised are being treated as high priority and extra resources are being deployed to ensure that all outstanding actions are resolved in the timeframe of the action plan.

The management and staff of Moate Nursing Home are committed to enhancing the quality of life of all our residents.

Provider's name: Pat Shanahan

Date: 3 November 2011