

**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, Louth.
<b>Telephone number:</b>	041 9818400
<b>Email address:</b>	sean@moorehalllodge.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>	Jillian Connolly
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	60
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following an application to vary registration conditions. This monitoring inspection was announced and took place over 2 day(s).

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

From:	To:
15 October 2014 10:30	15 October 2014 18:00
16 October 2014 10:30	16 October 2014 16:30

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

Moorehall Lodge Drogheda is a nursing home located in Co. Meath. The nursing home is one of two nursing homes operated by Moorehall Healthcare Limited. The nursing home was first registered under the Health Act 2007 in 2012 to provide services to 60 residents. Currently residents reside on the ground floor and the first floor.

The statement of purpose and function refers to the individual units of the designated centre as houses and the provider nominee informed the inspector that the organisation is structured around the 'Household' model. The inspector was informed that the aim was for communal areas to be designed for residents' convenience and comfort and built on the principals of home. In practice the inspector observed that the features of the model included each house having their own front door inclusive of post box and door bell. Each house also had a kitchenette and a homemaker which was a staff member who was employed to exclusively

ensure that the communal areas of the house were homely and needs outside of care activities were met, such as ensuring that residents could have a cup of tea whenever they wished or that activities were available throughout the day.

The ground floor consists of two ten - bedded houses and the first floor consists of two twenty bedded houses. Each house has single bedrooms with an en suite. The application submitted by the provider was for two houses on the second floor. Each house consists of twenty two single rooms with an en suite and one double room with an en suite. Therefore the provider was applying to increase the capacity from 60 residents to 108 residents.

Prior to the inspector completing the inspection residents and relatives completed questionnaires which were submitted to the Authority. On inspection, the inspector observed practice, reviewed documentation, inspected the premises and spoke with residents and staff. The inspector found that the current operational systems in place, such as staff supervision and audits, provide for a safe and quality service. Feedback obtained from residents and relatives was positive in respect of the service provided and residents feeling safe. Relatives stated that they were satisfied with the service their loved one received. Staff spoke positively about residents and were observed engaging with residents in a dignified and respectful manner.

The person in charge had changed since the last inspection conducted by the Authority and had commenced their position in August 2014. The appropriate notifications and documents had been submitted to the Authority in an appropriate time frame. The person in charge and the provider nominee were present at the feedback session.

Fourteen outcomes were inspected on this inspection and twelve outcomes were judged to be compliant. Improvements were required in the assessment and care planning of the health and social needs of residents. Non compliance was also identified in relation to the premises and is detailed in Outcome 12.

The action plan at the end of the report identifies areas where mandatory improvements are required in order to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Section 41(1)(c) of the Health Act 2007. 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.**

***Outcome 01: Statement of Purpose***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

As part of the application to vary the conditions of the designated centre, the registered provider was required to amend the Statement of Purpose and Function for the designated centre to reflect the increase in capacity from 60 to 108. This had not been submitted with the application however there was a copy available for the inspector to review on inspection. The inspector found that the document contained the information set out in Schedule 1 of the regulations. However as stated in Outcome 12, the twin rooms were only suitable to meet the needs of residents with an assessed dependency level of low to medium. This was not stated in the document as required under Schedule 1 2(b) of the regulations.

**Judgment:**

Non Compliant - Minor

***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:**

The inspector reviewed a sample of staff rosters and confirmed that the staffing compliment on the days of inspection were reflective of the standard staffing levels. The

inspector determined from observing practice that the staffing levels were sufficient to meet the needs of the residents. Staff spoken to confirmed same and stated that in the event that additional staffing was required this was facilitated. Residents spoken to stated that they did not have to wait for assistance. The inspector observed that if a resident utilised the call bell staff responded within a reasonable time frame.

The designated centre has a clearly defined management structure, and staff and residents were able to identify the relevant members of the management team. As stated previously, the person in charge had commenced their post two months prior to the inspection. Within each of the houses, there were staff members identified as team leaders with responsibility for staff supervision and co ordination of care activities on a day to day basis. They in turn report to the person in charge, who reports to the provider nominee. There was also additional personnel available, inclusive of a care manager, human resources and administration personnel. The inspector was assured by staff and residents that they could engage with the person in charge and the provider nominee as they were a regular presence in the designated centre. As the purpose of this inspection was to assist in a decision regarding an increase of capacity from 60 to 108 residents, the person in charge and the provider nominee stated that plans had commenced in a review of the current management structure and roles and responsibilities to cater for an increase in capacity.

The designated centre has a system in place regarding auditing of the service provided to ensure that it is safe, appropriate, consistent and effectively monitored. For example, on this inspection, non - compliance was identified in Outcome 11 regarding the health care needs of the residents. However through auditing this non - compliance had been identified by the person in charge and there was evidence that work had commenced to improve the existing assessment and care plan system. There was also evidence that residents are consulted and provided the opportunity to voice their opinions regarding the services provided through residents' forums and the complaints procedure.

An annual survey had been conducted with relatives and residents and the findings were displayed prominently in the public area of the houses. There was evidence that staffing rosters had been altered based on issues identified by residents and/or relatives. For example in one house, staff commenced their shift one hour later to remain on duty one hour later at night to ensure sufficient resources were available to meet the needs of the residents.

**Judgment:**  
Compliant

***Outcome 04: Suitable Person in Charge***

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

**Theme:**  
Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The person in charge had commenced their post two months prior to the inspection. The appropriate notification was submitted to the Authority regarding their commencement with the relevant documents to assure the Chief Inspector that they had more than 3 years experiences in a management capacity in the health and social care area and had experience of nursing older persons. As residents in the designated centre were assessed as requiring full time nursing care, the person in charge was a registered nurse. The inspector confirmed via the An Bord Altranais register that the person in charge is on the active register.

The inspector confirmed that the person in charge is employed full time in the designated centre. The person in charge had initiated a review of the quality of service in the designated centre. Evidence of changes to practice had included the introduction of a restraints register, a change to the prescription and administration of medication records and a review of care plans. The person in charge stated that she could fulfil their statutory role and demonstrated knowledge of the relevant legislation.

**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:**

There was evidence that the registered provider had prepared in writing the policies and procedures on the matters set out in Schedule 5. A copy of the policies were maintained in each of the individual houses and there was evidence that of the sample of staff reviewed, staff had read and understood the contents of the policy. Of the policies reviewed by the inspector, they had been updated in September 2014 following the commencement of the new Person in Charge. As stated in Outcome 18, the inspector reviewed a sample of staff files for staff that had been recruited to the designated centre as part of the expansion and determined that the documents listed in Schedule 2

<p>of the regulations were maintained.</p> <p>The inspector found that the records listed in Schedule 3 were maintained however as stated in Outcome 11 improvements were required in records regarding the assessment and care planning to ensure that they were consistently reflective of the individual needs of residents.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 06: Absence of the Person in charge</b>  <i>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.</i></p>
<p><b>Theme:</b> Governance, Leadership and Management</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The provider nominee was aware of the requirement to notify the Chief Inspector if the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more. The current arrangement for the absence of the person in charge is that the person in charge from another nursing home in the group would deputise in their absence.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 07: Safeguarding and Safety</b>  <i>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.</i></p>
<p><b>Theme:</b> Safe care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p>



**Findings:**

An action from a previous inspection was that not all staff had received the mandatory training in the detection, prevention and response to abuse in the appropriate time frame. The provider nominee informed the Authority in writing in September 2014 that they were satisfied that all staff had received the appropriate training. The inspector reviewed the training records of a sample of staff who were working in the designated centre on the day of inspection and confirmed that they had received the appropriate training.

The designated centre had a policy in place for responding to allegations of abuse, which was dated September 2014 and stated the different forms of abuse, the action to be taken in the event of a suspicion or allegation of abuse and the relevant bodies to report same. Residents spoken to in the designated centre stated that they felt safe and there were systems in place to support the policy to ensure any allegations or suspicion of abuse is investigated as per policy.

There were residents residing in the designated centre who had a history of exhibiting behaviours that challenge. There was evidence that this was addressed proactively through activities and communication methods. For example, the inspector observed staff redirecting a resident who was becoming agitated.

The designated centre had a policy in place regarding the use of restrictive practices. Restrictive practices utilised in the designated centre were in line with evidence based practice.

**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 designated centre had a Safety Statement in place and a risk management policy which were dated September 2014. There was also a risk register which was specific to the designated centre and identified the hazards and the appropriate control measures in place. For example the designated centre was a three story building and the assessment of risk included the stairs. There was also kitchenette areas in each of the living rooms and these had been assessed based on the risk of burns due to kettles and other appliances. The control measures in place included the area being supervised throughout the day by a member of staff. The risk management policy also included the risks specified in Regulation 26 (1)(c) of the Health Act 2007 (Care and Welfare of

Residents in Designated Centres for Older Persons) Regulations 2013. There was an incident/accident log in the designated centre which identified any incidents which had occurred in the designated centre and the learning which had occurred from same. For example, there was evidence that residents who had a fall had been reassessed in an appropriate time frame and control measures put in place. As the second floor had yet to be completed to ensure it was fit for occupancy, there had been considerable building work in the designated centre. The provider had evidence that this had been risk assessed and planned to ensure minimal disruption to residents. Residents informed the inspector that although they could at times hear the building work occurring the disruption was minimal and they were informed of the progress at all times.

There was a policy in place regarding infection control. Each household had a room dedicated to the storage of cleaning equipment and chemicals. There were cleaning logs maintained and personal protective equipment available for staff. In September 2014, one household had a confirmed outbreak of the Norovirus which had been notified to the Authority. There was evidence that the outbreak had been effectively managed and therefore contained to the relevant house.

As part of the application the provider was required to provide written confirmation from a properly and suitably qualified person with experience in fire safety design and management that all statutory requirements relating to fire safety and building control have been complied with. There were adequate means of escape with the appropriate equipment to assist with evacuating residents down the stairs in the event of an emergency. The designated centre is divided into fire zones therefore there was a system of horizontal evacuation in place. The fire panel was reflective of same. There was evidence that fire equipment was serviced and maintained at regular intervals. Of the sample of training records reviewed staff had completed training in the prevention, detection and management of fire. There was evidence that simulated evacuations had taken place and the person in charge stated that it is the intention to increase the frequency of same once the second floor is operational to account for the increase risk based on the increase in the number of residents. Residents had personal evacuation plans which were maintained in a fire register in each house and staff demonstrated that they were aware of the procedures to be undertaken in the event of an emergency. The provider had an agreement in place with a local hotel, that in the event of an emergency which required a full evacuation residents would have alternative accommodation.

**Judgment:**  
Compliant

### ***Outcome 09: Medication Management***

*Each resident is protected by the designated centre's policies and procedures for medication management.*

**Theme:**  
Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The organisation had written policies in place regarding the ordering, prescribing, storing and administration of medicines to residents. The designated centre utilises a monitored dosage system and has a policy in place that medication will only be administered by a registered nurse. The four operational houses have a clinical room in place which contain a medication cupboard and a separate cupboard for the storage of controlled drugs. The inspector reviewed the register of controlled drugs and confirmed that they were checked daily by two staff nurses on the commencement of each shift. It is proposed that for the two new houses on the second floor that there will be one shared clinical room. Medication will be stored in a locked press in each individual living room. The change in practice was as a result of feedback obtained by staff in respect to efficiency.

As stated previously, a new system of prescription and administration records were introduced to the designated centre. Of the sample reviewed the records contained all of the necessary information and the administration times correlated with the prescription times. Medications which were crushed were prescribed. There was a system in place for recording medication errors. There had been two medication errors in the designated centre since the previous inspection. There was evidence that this had been managed in accordance with the policy of the organisation. There was also a system in place for the returning of medicinal products which were out of date or unused.

**Judgment:**

Compliant

***Outcome 11: Health and Social Care Needs***

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

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The designated centre utilises an electronic system for documenting the assessment of residents' needs and any subsequent care plans which are created as a result of an identification of need. Of the sample of files reviewed, assessments such as Manual Handling, risk of pressure sores, nutritional status and dependency level were undertaken and reviewed at the appropriate intervals. The inspector confirmed that

residents had access to a general practitioner at appropriate intervals. There was evidence that if a need was identified that required additional expertise the appropriate referral was made to the relevant Allied Health professional.

Over the two days the inspector identified that there was improvement required in the information recorded both at the assessment stage and during the development of care plans as it was inconsistent. In some instances the information was generic and not reflective of the resident and the actual interventions they required. However in other instances they were individualised and reflective of the care the resident received. For example, the inspector observed residents being assisted to eat by staff at dinner time and the consistency of their food had been modified. This was in keeping with the initial assessment and referral to a Speech and Language Therapist. The recommendations of the speech and language therapist were recorded in a hard copy document and then transferred to the electronic care plan of the resident to ensure continuity of care.

There were also inconsistencies in the assessment of social care needs of residents and documented evidence that social care needs were being met. The designated centre utilises the 'household' model and the inspector was informed by the provider nominee during the course of the inspection, of the importance of creating a homely person centred environment for residents. The inspector spoke to residents and observed practice and was assured that there was a wide variety of activities available for residents to partake in on a daily basis. For example, the inspector observed arts and crafts, singing groups and a choir at different times throughout the inspection. However there was an absence of social care plans for some residents.

The inspector discussed this inconsistency with the person in charge and staff. The person in charge demonstrated that the deficits in documentation not being individualised had been identified through an audit prior to the inspection. There was a clear plan in place regarding the development of staff skill in care planning and review of all care plans in the designated centre. The inspector also identified improvement was required in the daily progress notes as at times they were generic and did not reflect of the actual care interventions the resident received as per their care plan.

**Judgment:**  
Non Compliant - Minor

***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):**

No actions were required from the previous inspection.

**Findings:**

The inspector found that the four houses which were operational on the day of inspection was designed and laid out as to meet the needs of the residents. They were maintained in a good state of repair and clean and suitably decorated, with residents' rooms being personalised. There were examples of residents bringing their own furniture into the designated centre. As each resident had their own room and en suite there was sufficient private and communal space for residents.

The provider had applied to open two new houses, each with twenty four beds. Each house consists of twenty two single bedrooms with en suite and one twin bedroom. There was also a living/dining room with a small kitchenette and an alcoved sitting area. There was also a room containing an assistive bath and toilets for staff and visitors. The houses will share a laundry room that residents can utilise to do their own laundry, a clinical room and a visitors' room. The inspector formed the view that the premises were suitably decorated and homely and had the adequate equipment such as grab rails and safe floor coverings. The inspector reviewed the bedrooms and found that although the twin rooms were of a size that is stipulated in Standard 25 of the National Standards for Residential Care Settings for Older People in Ireland 2009 published by the Authority. The layout of the room was not conducive to assistive equipment, such as hoists being utilised around the beds, therefore it was only suitable for residents who had an assessed need of low or medium dependency. There were two single bedrooms, one in each of the houses which were not fit for purpose due to inadequate natural lighting. The inspector determined that for a resident to comfortably engage in activities in their bedroom, artificial lighting would be required at all times of the day. This was as each of the windows faced onto the roofed veranda/outdoor area reducing the natural light available. The location of the windows also impinged on the privacy that would be available to each room as whilst standing on the veranda the inspector could clearly see into each room. Whilst the Statement of Purpose and Function contained all of the items as stated in Schedule 1 of the regulations, it did not reflect the assessed needs that the twin rooms could meet therefore required amendment as stated in Outcome 1.

**Judgment:**

Non Compliant - Moderate

***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:**

The designated centre has a complaints policy which was dated September 2014. The policy was also displayed in prominent locations throughout the designated centre and in the residents' guide. The inspector reviewed the complaints procedure and determined that it contained all of the information as stipulated in Regulation 34 (1). There was a record of complaints maintained in the designated centre. There was no complaints recorded however there had been quality issues identified. The inspector reviewed the quality issues and found that each issue had been investigated and actions taken on foot of a quality issue were fully and properly recorded. The record of complaints and quality issues were recorded and maintained centrally for all of the existing four houses. However the person in charge, stated that once the two additional houses were operational, each house would maintain their own log. This log would be subject to regular audit and review by management. Residents stated both through the questionnaire submitted to the Authority and verbally to the inspector that they were satisfied that they could make a complaint and were able to identify the relevant member of staff.

**Judgment:**

Compliant

**Outcome 15: Food and Nutrition**

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The designated centre had policies and procedures in place regarding the nutritional and hydration needs of residents. As stated previously the designated centre operates a 'household' model of care. One aspect of this is the role of a homemaker who is employed solely to attend to residents needs in the communal areas. As a result, residents had access to a safe supply of fresh drinking water at all times and other refreshments such as tea and snacks. One resident reported that there was 'too much' tea, confirming to the inspector that there was no restrictions in place. The inspector joined residents for a dinner and witnessed residents being offered a choice of meals utilising the written menu or by the two alternatives being placed in front of the resident depending on their communication needs. The inspector found the food was well presented and hot and the dining experience was a relaxed and social experience. There were sufficient staff available to meet the needs of the residents and staff supported residents in a dignified and respectful manner.

The inspector reviewed a report which was conducted by the environmental health officer and the follow up report completed by the provider to the environmental health officer to confirm that all recommendations had been addressed.

Residents were weighed monthly or sooner based on their nutritional assessment. There was evidence that appropriate referrals were made to the relevant Allied Health Professionals. As stated in Outcome 11, there was evidence that the dietary needs of residents as prescribed by dietetic staff were met in accordance with the individual care plan of the resident concerned.

The person in charge demonstrated to the inspector that additional training was to be provided to staff for Percutaneous endoscopic gastrostomy (PEG) feeding tubes based on a need identified.

**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:**

As stated in Outcome 11, the inspector observed recreational activities taking place throughout the two day inspection. One of the activities was a community choir who practice weekly in the designated centre and residents attend. Residents reported in the questionnaire submitted to the Authority that they were satisfied with how they spend their day.

The inspector observed residents being spoken to with dignity and respect by staff. As each resident had their own bedroom personal care activities were able to be undertaken in private. There were televisions and radios available in the communal areas and a portable telephone which residents could access. Each house held learning circles regularly which were opportunities for residents to discuss the day to day activities and plan for special occasions such as Easter. There was also a residents' forum which was facilitated by a relative of a resident and access to an independent advocate if necessary. Residents informed the inspector that they felt consulted/involved and were aware of the expansion process and the planned opening of the second floor.



There was a policy in place regarding visitors and the inspector observed visitors being welcomed throughout the two days. There was a private area for residents to meet visitors if required. There was a sign in book for visitors at the main entrance.

**Judgment:**  
Compliant

***Outcome 18: Suitable Staffing***

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

**Theme:**  
Workforce

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

No actions were required from the previous inspection.

**Findings:**

The inspector reviewed a sample of rosters and confirmed that the staffing levels observed on the day of inspection were consistent with the average staffing levels. Residents informed the inspector that they were satisfied that their needs were being met and the inspector observed staff attending to residents' needs in a timely manner. The inspector confirmed that there was always a registered staff nurse on duty.

The inspector discussed with management the proposed staffing for the opening of the additional 48 beds. The inspector was informed that an analysis had been undertaken and recruitment had commenced to ensure that the appropriate staffing was available prior to opening. Additional identified staffing included an additional care manager, administration staff, catering staff, laundry staff, household staff, care staff, homemakers and registered nurses. The inspector was informed that the staffing would be reviewed and addressed to ensure that the appropriate number of staff and skill mix would be in place based on the needs of the residents due to be admitted. The inspector reviewed a sample of staff files of staff who had been newly recruited and was satisfied that the relevant information as stipulated in Schedule 2 had been received for each staff member. There was evidence that staff received annual appraisals which were conducted by management and human resources and this appraisal was utilised to inform the training needs of staff.

The inspector reviewed a sample of staff training records and was satisfied that staff on duty had received the appropriate mandatory training. The person in charge had also completed an audit of staff training needs and had planned training in relation to same. For example, hand hygiene training, care planning training and training relating to PEG



feeding tubes. All new staff will complete an induction week prior to completing a rostered shift and the human resource department outlined to the inspector the content, which will include all mandatory training and training specific to certain roles such as HACCAP training. The training will also focus on the ethos of the organisation which is stated in the Statement of Purpose and Function of 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:***

Jillian Connolly  
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>	15/10/2014
<b>Date of response:</b>	16/11/2014

#### 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 01: Statement of Purpose

**Theme:**  
Governance, Leadership and Management

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

The statement of purpose and function did not address the specific care needs that the twin rooms on the second floor are intended to meet.

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

**Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The version of Statement of Purpose which included the additional 48 beds was made available to the Inspector and the amendment required completed.

**Proposed Timescale:** 06/11/2014

**Outcome 11: Health and Social Care Needs****Theme:**

Effective care and support

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

There were inconsistencies in the assessment of need of residents, with some being generic and not reflective of the actual need of residents. There was also an absence of social care plans for some residents.

**Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

All residents will have individualized person centred comprehensive assessment of their needs completed within 48 hours of admission. This assessment of need also incorporates social care needs. In addition we have amended our Care Planning and Implementation Policy to reflect this.

**Proposed Timescale:** 16/12/2014

**Theme:**

Effective care and support

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

Care plans created were not always reflective of the actual assessment of needs of residents.

**Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

We use an electronic care record. Over the last three months we have reviewed the templates and worked with the supplier to make care records more personalised and less generic. As a result all resident care plans are being updated and are now reflective of each resident's individual needs. We have also strengthened our social care plans and integrated in care plans a persons "Life Story" to ensure we reflect clinical, care and social care needs into a single care plan. We are also completing a training programme for staff to ensure we fully implement a comprehensive approach to care planning. Care planning improvements by 16th December 2014 and training in care planning to be completed by 30th November 2014

**Proposed Timescale:** 16/12/2014

**Outcome 12: Safe and Suitable Premises****Theme:**

Effective care and support

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

There was inadequate natural light in one single room in each of the houses on the second floor as required by Schedule 6 3 (n) of the regulations.

**Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

During the inspection visit it was noted by the Inspector that bedrooms 1 in both of the new 24 bed Households had a) a privacy issue and b) reduced daylight when compared to the adjoining rooms. Immediately after the Inspection, the Registered Provider engaged the services of our specialist design team to carry out an assessment of both of these issues and in particular the current daylight reduction which occurs in both bedrooms on level 2.

The 2 rooms face directly on to balcony area which is covered by a roof structure. It is this roof structure which is shading the windows into the 2 affected rooms. A comprehensive appraisal was undertaken and report produced which was submitted to HIQA for information as part of our application to vary our registration conditions increasing bed numbers from 60 to 108. This report outlines the proposal for substantial increase of daylight entry into both rooms by the introduction of new roof over with glazed roof light. In addition, a flower screen will also be placed on the

balcony to address the concern of privacy. This screen has been modelled into the light analysis undertaken by the deigned team and it will not reduce natural light flow into both rooms. This work will be completed by 17th December 2014

**Proposed Timescale:** 17/12/2014

**Theme:**

Effective care and support

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

The twin rooms of the second floor did not provide adequate space for residents with an assessed dependency need of high to maximum or for residents who required assistive equipment as required by Schedule 6 (3) (g).

**Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

It was agreed with the Inspector on the day of inspection that these two twin rooms were compliant. Having said that, we agree to amend the Statement of Purpose to ensure the operating procedures of both rooms do not compromise the privacy and dignity of residents.

**Proposed Timescale:** 06/11/2014