

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Cairn Hill Nursing Home Bray
<b>Centre ID:</b>	OSV-0000755
<b>Centre address:</b>	Herbert Road, Bray, Wicklow.
<b>Telephone number:</b>	01 201 4699
<b>Email address:</b>	info@cairnhill.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	McMahon Healthcare Limited
<b>Provider Nominee:</b>	Brian McMahon
<b>Lead inspector:</b>	Deirdre Byrne
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	91
<b>Number of vacancies on the date of inspection:</b>	2

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

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

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

From:	To:
28 June 2016 09:30	28 June 2016 19:00
29 June 2016 08:00	29 June 2016 17:00

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

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

**Summary of findings from this inspection**

The provider had applied to renew the registration of the designated centre. This report sets out the findings of the inspection. As part of the inspection, the inspector met with residents, relatives and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspector found the provider demonstrated a willingness 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.

Cairn Hill Bray Nursing Home is a purpose built building and it is located in a suburban area. It has capacity to accommodate 93 residents and the service provides long term care to adults.

Overall, there was a commitment by the provider of the designated centre to comply with the requirements in the regulations and standards. There were suitable governance and management systems in place. There was a system of continuous monitoring of the service and an annual review of the quality and safety of the service had been developed.

There were robust recruitment and induction arrangements in place, and staff had access to a range of training and had completed all mandatory training areas. The staff were familiar with the residents and knowledgeable of their health-care needs. The inspector observed residents treated in a kind and respectful manner by staff, and this in turn was confirmed and commented on by residents and relatives.

The residents had good access to general practitioner (GP) and allied health services. There was evidence of timely response to ensure the residents' health care needs were met. There were full time activities staff who facilitated a range of activities for residents to take part in during the day.

The centre was maintained in good standard of hygiene and repair, with a range of assistive equipment to support residents. It was nicely decorated and furnished in a homely style.

Many residents and families comments both in the questionnaires and who spoke to the inspector confirmed they had a wide range of interesting things to do during the day.

However, there were some areas of improvement identified and included:

- an area of monitoring the quality and safety of care,
- an aspect of medication management
- an aspect of healthcare,
- staff knowledge of fire safety procedures
- staff levels at times of the day.

There were no actions to follow up on from the previous inspection.

The issues identified at this inspection matters are outlined in the report and the Action plan at the end of the report.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

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

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied a written statement of purpose was developed for the centre that met the requirements of regulation 3 and schedule 1 of the regulations.

The statement of purpose outlined the aims, mission and ethos of the service. It provided a clear and accurate reflection of facilities and services provided.

**Judgment:**

Compliant

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspector found there was a clearly defined management structure that outlined the lines of authority and accountability. There were systems in place to review the safety and quality of life of residents. There was an area of improvement identified in relation this area.

The centre is operated by McMahon Health Care Limited. There is a board of directors in place who oversee the governance of the centre. A defined senior management team was in place that included the provider, the person in charge, the general manager and the support services manager. There were arrangements in place for the senior management team to meet and monthly management meetings took place. The meetings were attended by the provider, general manager, person in charge and senior staff. A sample of the recent meetings minutes was read. Also, detailed action plans were developed, that outlined a range of decisions to be taken in areas such as: governance, human resources, incidents, quality and safety.

The provider who was based in the centre full time also met the person in charge on a regular basis. The general manager also worked closely with both the provider and the person in charge.

The inspector found there were governance and management systems in place to monitor the quality and safety of care provided to residents. There were some improvements required in order for the centre was in full compliance with some aspects of the regulations as outlined in findings of this inspection in Outcomes 7 (health and safety), 9 (medication management) and 11 (health and social care needs).

There were systems in place to monitor the service provided to residents. A sample of audits for 2015 was seen and these included dementia care, residents' rights, care plans, health and safety, medication management, end-of-life care. These were detailed audits that included action plans to bring about improvement. Some of the issues identified by the inspector in relation to Outcome 11 had been picked up on in the care planning audit. However, some improvements had still to be brought about. While audits had been completed in 2016 and included complaints, hand hygiene and medication management, there had been no audits of clinical care areas carried out or to follow up on the issues identified in the 2015 audits. In addition, internal medication management audits did not take place with sufficient frequency to ensure review of practice. The person in charge and the general manager showed the inspector an audit schedule for the remainder of 2016 that would include clinical audits. Following the inspection the provider submitted a quality improvement plan which that outlined the proposed actions in place for each audit carried out. The document had been prepared prior the inspection, but it was not provided on the inspection day.

There were multi-disciplinary meetings were taking place every three months and the person in charge said key performance indicators (KPIs) were reviewed on a weekly basis. It was noted that the minutes of these meetings read did not outline details of the KPIs, decisions and actions to be taken in relation to residents and clinical risk.

An annual report on the review of the safety and quality of care provided to residents was seen by the inspector. It was a comprehensive document that included detailed findings and actions to bring about improvements in the centre. The inspector discussed the findings of the report with the general manager. The report had been done in consultation with residents, and results of the satisfaction surveys for the centre were incorporated into the review. The general manager outlined how the findings of the report would be shared with residents and relatives and a consultation process would

take place in the centre.

**Judgment:**

Non Compliant - Moderate

***Outcome 03: Information for residents***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that each resident had an agreed written contract and a guide to the centre was provided to each resident on their admission.

A sample of residents contracts reviewed confirmed each contract was signed on their admission the centre. The contract included the services provided and the fees charged.

The contract of care stated there was a fixed monthly charge for the social programme. This was discussed with the provider nominee who said residents were informed prior to their admission about the additional charges. The programme was available to all residents irrespective of their dependency levels. This was evidenced during the inspection as outlined in Outcome 11 (Health and Social Care Needs).

There was a residents' guide to the centre that summarised the complaints process, the visitors' policy, services provided in the centre and the emergency procedures. Residents confirmed they had received a copy and a comment in one questionnaire received stated "I was provided with a booklet about my rights". One resident told the inspector about feedback they had given to management on the document.

**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 inspector was satisfied that the centre was managed full time by a registered nurse with experience in care of the elderly.

The person in charge had completed mandatory training and she continued her own professional development by participating in additional training in the centre to meet the healthcare needs of the residents.

The person in charge had completed a post registration management qualification. The person in charge who outlined plans to complete additional management courses in the near future.

The residents were able to identify the person in charge to inspectors. The staff informed the inspector that they felt supported by the person in charge.

She was supported in her role by three clinical nurse managers who deputised in her absence.

**Judgment:**

Compliant

***Outcome 05: Documentation to be kept at a designated centre***  
***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The provider ensured all documents as outlined in schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval.

There were policies and procedures in place as required by schedule 5 of the regulations. The policies were regularly reviewed, were centre specific and comprehensive to guide practice.



There was evidence to confirm the centre was adequately insured against loss or damage to residents' property, along with insurance against injury to residents.

There was a hard copy directory of residents that contained mandatory information such as date of admission, transfer to and from the centre, and next of kin details.

**Judgment:**  
Compliant

***Outcome 06: Absence of the Person in charge***  
***The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The inspector was satisfied the provider had adequate arrangements in place should the person in charge take leave requiring notification to the HIQA.

There were formal measures in place in the event of any such absence.

**Judgment:**  
Compliant

***Outcome 07: Safeguarding and Safety***  
***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**  
Safe care and support

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

**Findings:**  
The provider had ensured there systems in place to protect residents from being harmed

or suffering abuse. There were measures to ensure a positive approach to manage expressive behaviours. Restrictive practices carried out, were done in accordance with the regulations and national policy, with some improvements identified.

It was evident that the National Policy "Towards of Restraint Free Environment" was being implemented in the centre. However, progress was required in some areas. For example, 25 residents used bedrails. The person in charge told the inspector she regularly reviewed bed rail usage and the residents where possible were encouraged to remove bedrails. There was evidence a reduction in the use of "as required" (PRN) medication to manage behaviours. The person in charge reviewed the use of these medications and documented checks were carried by nursing staff prior to any such medication being administered.

A comprehensive centre specific policy on the use restrictive practices was read by the inspector. However, it was not fully implemented in practice. For example, alternatives to the use of bedrails were not consistently documented as per the centres policy. There was evidence of regular risk assessments being carried out and care plans developed to guide staff practice.

There was a detailed policy on the protection of vulnerable adults. It referenced the Health Service Executive (HSE) Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. The policy included information on the types of abuse, the reporting arrangements and the procedures to investigate an allegation of abuse. Records read confirmed all staff had received training in the prevention of abuse. The training was completed on line by staff. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

There had been allegations of suspected abuse notified to HIQA since the last inspection. The inspector found appropriate action had been taken by the person in charge and the provider. The person in charge and the general manager were both familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. The person in charge was aware of the requirement to notify any such allegation to HIQA.

There were systems in place for the safeguarding of residents' money. The balances of some residents' monies matched the quantity being held in safekeeping.

All residents spoken to said that they felt safe and secure in the centre. Residents stated that they attributed this to the staff who they said they were caring and trustworthy. There was a secure entrance to the centre, with a staffed reception until 9pm each evening. There was a visitor's book in place.

The inspector read a policy on the management of responsive behaviours which guided staff practice. At the time of inspection a small number of residents presented with expressive behaviours. There were regular assessments completed for these residents and care plans were developed to guide the practice to be delivered. An area of improvement in relation to the care plans read is outlined in Outcome 11. Staff informed the inspector how to handle certain situations with residents. They used evidenced based tools to record incidents when required.

**Judgment:**

Non Compliant - Moderate

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

***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found the provider had systems in place to manage risk and spread of infection in the centre. An area of improvement was required regarding staff knowledge of the procedures to be followed in the event of a fire.

There were systems and procedures in place to prevent the spread of fire and to respond to a fire alarm. Training records read confirmed all staff had attended training within the last year, and training was provided twice a year to staff. However, some staff spoken to were not fully aware of the procedures to follow in the event of a fire. For example, the role of the fire marshal and the person responsible for calling the fire brigade.

The above matters were brought to the attention of the provider who took immediate action before the end of the inspection. The action taken was as follows

- the provider revised the fire safety procedures which he displayed at each nurses station the building,
- the weekly fire drill would be enhanced to include additional education for staff,
- a new fire drill record was developed to be used at the weekly fire drills,
- the drills would take place at different times to capture staff working different shifts times in the centre.

Fire drills were taking place at regular intervals. There had been at least two unannounced fire drills per year. The maintenance manager also oversaw a weekly fire drill test.

Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits, were checked on a daily basis, were unobstructed.

An up-to-date safety statement was seen by the inspector. There were risk management policies in place that met the requirements of the regulations. There were three risk registers for the centre. Risks were identified, evaluated and had controls in place for mitigation. These were regularly reviewed at the monthly management meetings and

updated by the general manager

The inspector saw residents were encouraged to be actively mobile and were seen being escorted around the centre. There were two physiotherapists based in the centre who provided additional support and assessment of residents at risk of falls. There was a falls prevention committee that met every month, and a review of each falls took place. A sample of the minutes for the recent meeting was read, there were detailed minutes and a record of action taken along with preventative measures put in place to prevent future falls occurring.

The staff had completed up-to-date training in the movement and handling of residents. There was safe floor covering and handrails throughout the centre, and three lifts accessed the centres four floors.

An emergency plan that guided practice was in place, which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency. Alternative accommodation was available in the event an evacuation of residents took place.

The inspector found measures and policies were in place to control and prevent infection. Records read confirmed staff received training in infection control and hand hygiene. There was access to supplies of gloves and disposable aprons and staff were observed using the alcohol hand gels which were available throughout the centre.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found residents were protected by the designated centre's policies and procedures for medicine management. However, some areas of improvement were identified.

Overall, nurses were observed to administer the prescribed medicines for each resident in line with professional guidelines. However, some improvements were identified:

1. The administration of as required (PRN) required improvement. For example, some medicines were administered without the maximum dose in a 24 hour period prescribed. This was a breach the policy and professional guidelines.

2. There were pre-populated medicine administration records that the staff nurses used to record when medications were administered to residents. However, some administration sheets did not include the time in the 24 hour clock which could lead to confusion. For example, "breakfast, lunch, dinner" was used and not 24 hour clock to reflect the time on the prescription sheet.

These matters were brought to the attention of the person in charge who assured the inspector action would be taken.

Nurses were provided with protected time during each medicine rounds and wore an apron that highlighted to other staff what that they were not to be disturbed.

All nurses had completed medicine management training. The nurses completed an online course on an annual basis.

Medicines that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked a sample of balances and found them to be correct

All medicines were securely stored in a locked room in a locked medication trolley. A secure fridge was provided for medicines that required specific temperature control.

There had been 11 medicine errors in 2016. An incident form was completed and investigation carried out by the person in charge. There were documented records of the action taken, improvements brought about, and learning for staff.

There was a system in place for monitoring safe medicine practices. Audits were carried out internally by the person in charge. An area of improvement is outlined in Outcome 2.

There were also audits completed by the pharmacy service every six months or as required.

**Judgment:**

Non Compliant - Moderate

***Outcome 10: Notification of Incidents***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Overall, practice in relation to notifications of incidents was satisfactory. There was an electronic database of incident and accident records maintained in the centre.

The person in charge was aware of the legal requirement to notify HIQA regarding incidents and accidents.

The inspection found from a review of relevant incidents that these had been notified to HIQA by the person in charge.

**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 inspector found nursing staff had a good knowledge of the residents health care needs and there was evidence residents received timely intervention when concerns around clinical risks were identified. However, the documentation and review of care plans and the management of wound care required improvement.

Residents were comprehensively assessed on admission to the centre. There were recognised tools used to assess residents clinical and health-care needs on a four monthly basis. There was information on each resident documented clearly on a daily basis in their nursing notes or within the vital signs were carried out on a monthly basis for example, body-mass-index (BMI), weight, blood pressure, temperature.

The nursing staff were familiar with the residents and spoke knowledgeably of their health care needs however, the documentation and review of care plans require improvement:

- the care plans for some residents did not fully reflect staff practices or the care to be delivered to residents. For example, management of responsive behaviours, risk of wandering, falls prevention, epilepsy/seizure care, diabetes management and weight loss.

- care plans were not developed for some residents' identified healthcare needs. For example, wound care.

These matters were discussed with the person in charge who assured the inspector appropriate action would be taken to address the issues identified.

There was evidence of consultation with residents in their care plan reviews, with some improvements required. A number of residents and some family members confirmed that they were consulted with in the development of care plans. Some questionnaires stated "I have had meetings with staff and family regarding every day events and also end of life scenario" and "we had meetings in relation to (resident name) care plan". However, there were inconsistent records maintained when the consultation took place.

There were policies in place for the management of wound care. However, practice in this area required improvement. For example, there were gaps in the completion of the wound assessments for these residents. For example, one resident who had a wound since April 2016 had only four recorded assessments completed. A tissue viability nurse had reviewed one resident and recommended a detailed treatment and dressing regime. However, as reported above, there was no wound care plan developed to incorporate this advice into. This was brought to the attention of the person in charge who was required to take immediate action. Following the inspection an updated care plan for the resident was submitted to HIQA.

The inspector found policies and procedures were in place for the management of nutrition and the prevention of falls in the centre. Staff were familiar with these procedures.

Residents' health care needs were supported by good access to GP services and an out-of-hours GP service was available. If preferred, residents could retain the services of their own GP.

The residents had good access to a range of external allied health professionals such as dietician, speech and language therapist and psychiatric services. There were two physiotherapists employed by the service. Letters of referrals and appointments to these services were seen on residents' files.

The inspector found there were systems in place to ensure the social care needs of residents. There were social care assessments completed for each resident. A social care plan was developed outlined the residents' level of ability and what activities they like to take part in.

**Judgment:**

Non Compliant - Moderate

***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 design and layout of the centre was suitable for its stated purpose and it met the needs of the residents.

The centre was a purpose built nursing home that could accommodate 93 residents. It was comprised of three floors that contained suitable and homely accommodation for between 29 and 34 residents depending on the unit.

Residents' accommodation was also provided over the three floors and there was an additional basement area where a laundry, staff facilities including showers toilets and lockers, a kitchen and dining area, separate catering staff facilities, offices, storage areas and maintenance areas were located. The hairdressing salon was also located here.

The bedroom accommodation met residents' needs for privacy, leisure and comfort. There were 83 single bedrooms and five two bedded rooms, all with full en suite facilities. Bedrooms were appropriately furnished to a high standard with a specialised bed, wardrobe, locker, chair and desk. All had coordinating curtains and bed clothes. Each room had a different coloured door which was designed to look like a domestic front door. The inspector visited a number of bedrooms with these residents' permission. Many residents had personalised their rooms, with furniture, paintings, and personal items.

All bedrooms had call bell facilities. In addition, portable call bells were available to residents who wished to use them while visiting other parts of the centre. Under floor heating was provided in all rooms, which could be thermostatically controlled in each room. To support residents and enhance safety, lights automatically turned on as residents entered their room.

There were additional assisted toilets and bathrooms on each floor and these were located where residents mobilised and had activities for example, close to sitting rooms and along the corridors. A wheelchair accessible visitor's toilet was also available.

There was appropriate use of colour and textures in the design throughout the centre. A variety of communal day and dining space was provided on each floor. The day and dining rooms were bright with large windows. In addition, there was a fully equipped kitchenette on the first and second floors. The provider said that this could be used by visitors and residents and was also to be used as part of the activity programme.

The corridors were wide and would allow residents to easily move about when using assistive equipment such as walking frames and wheelchairs. Handrails were provided in



all corridor areas to promote independence.

There was a sluice room on each floor which were fully equipped with suitable ventilation. There was adequate storage space provided to ensure that equipment and assistive devices were stored in a safe and discreet manner.

There are three lifts which provide access to each floor (one service lift, one lift suitable for moving beds and a passenger lift).

A landscaped garden was directly accessible to the residents from the ground floor, and it contained appropriate garden furniture. It had lovely views of the area. It was reported in a number of questionnaires that residents who required staff support would like to get out into the garden more. There were a number of residents using the garden during the inspection. It was commented on by families to the inspector that staff did encourage residents to use the garden, which was generally based on staff availability.

**Judgment:**

Compliant

***Outcome 13: Complaints procedures***

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The provider demonstrated a positive attitude towards complaints. There was a complaints policy and procedure that met the requirements of the regulations.

A complaints procedure was prominently displayed in each unit. It contained the guidance to make a complaint including an appeals process. The inspector reviewed the records of logged complaints and good practice was found in the investigation of complaints by the complaints officer. The policy in the centre was that all complaints would be resolved locally before progressing to the formal complaints procedure.

The residents and relatives told the inspector they would talk to the person in charge or a member of the senior nursing staff if they had any complaints, and that they were approachable. Residents reported in questionnaires they would "talk to owner" and "the nurse on duty".

**Judgment:**

Compliant

***Outcome 14: End of Life Care***

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that end-of-life policies and procedures were in place. There were systems in place to record resident's wishes and preferences.

An end-of-life policy reviewed provided guidance to staff. The inspector was informed that no residents were approaching end-of-life care on the day of inspection.

There was access to the local palliative care team who provided support and advice when required.

There were a number of private areas and meeting rooms available for relatives and friends for privacy if required.

There was accommodation available to relatives if they wished to stay in the centre overnight with their loved one.

**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 inspector found each resident was provided with food and drinks at times and in quantities adequate for his/her needs.

Food was properly prepared, cooked and served, and looked wholesome and nutritious. The inspector spent time in one dining room during the lunch time meal. It was a calm, sociable time for residents. The room was maintained to a good degree of cleanliness. Where required, residents were discreetly and patiently assisted by staff. The menu was displayed on the wall on a white board. During the inspection the provider nominee showed the inspector a menu that would be displayed on each table at mealtimes.

The dining experience was pleasant. Tables were nicely laid and meals were appetisingly presented. Residents told inspectors they enjoyed the meal and there was a range of choice available.

The care staff supervised during the mealtime. It was observed there was no nurse present to oversee the mealtime and the provision of modified consistency diets for residents. The nursing staff oversaw the administration of residents' medications at this time. The inspector did not observe any negative outcomes at mealtimes during the inspection. Where dietary recommendations had been made by specialist services in the past, these were documented and found to be followed by the staff.

The inspector visited the kitchen and noticed that it was well organised and had a plentiful supply of fresh and frozen food which was stored appropriately. The chef on duty discussed the special dietary requirements of individual resident's and information on residents' dietary needs and preferences. He told inspectors that he sought feedback from residents and got information from the staff on residents' preferences.

**Judgment:**  
Compliant

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

**Theme:**  
Person-centred care and support

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

**Findings:**  
The inspector found the provider was committed to ensuring a culture existed that respected the residents' privacy and dignity, and consulted with residents in how the centre was organised.

A sample of comments in the residents' questionnaires confirmed residents were happy that their rights were respected. Some residents stated their rights include "privacy and right to know about my health and care" and "staff help to choose clothes so I am presentable, staff constantly check on me". The privacy of residents was respected. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. The inspector observed staff interacting with residents in a friendly and courteous manner.

The residents had opportunities to take part in activities and had interesting things to do during the day. There were three activity coordinators employed on a full time basis. They were based on each of the three floors in the centre. A detailed and up-to-date programme of activities displayed in the reception area of these units. There were activities taking place every day and these consisted mostly of group activities such as exercise classes, bingo, baking and on other days, music sessions. A number of external service providers also visited the residents to facilitate activities such as music therapists and dog therapy.

Many residents and families comments both in the questionnaires and who spoke to the inspector confirmed they had a wide range of interesting things to do during the day. One comment in the questionnaire stated there was "an excellent range-quizzes, music, films, discussions, exercises. Also visiting musicians, art class, all which (resident name) enjoys".

A hairdresser visited the centre twice weekly and there was a fully fitted out treatment room located in the basement area.

Residents' civil and political rights were respected. The provider told inspectors about the arrangements with the local county council for residents to vote in-house at each election.

There was an open visitor's policy to the centre. There were a number of private meeting rooms and communal areas where residents could meet visitors in private.

The provider said that residents from all religious denominations were supported to practice their religious beliefs. There were Church of Ireland and Roman Catholic religious services held on the centre.

There was a residents committee on each of the three floors which met every three months. The facilitators were the activities coordinators. Following each meeting, the person in charge was given the minutes of the meeting and would address any issues identified. The minutes were also displayed on the residents' notice board in each unit. From a sample of minutes read, it was evident that action had been taken to bring about improvements.

An independent advocacy service was also available to the residents. Their contact details were prominently displayed in the centre.

Residents had access to a hands free telephone. Newspapers were available and all bedrooms were provided with a television.

**Judgment:**  
Compliant

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

**Theme:**  
Person-centred care and support

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

**Findings:**

The inspector was satisfied that there were adequate arrangements in place to protect resident's possessions and to allow residents to maintain control over their own possessions.

There was suitable storage space for residents clothing and any other personal possessions. A lockable drawer was available in each resident's bedroom. There was a list maintained of each resident's personal possessions.

There was a fully fitted laundry facility. After clothing was laundered it was then returned to the residents bedrooms by staff.

The inspector spoke to some residents and family members who were satisfied with the laundry arrangements. Comments received in the questionnaires stated "all clothing labelled and laundered to perfection" and "exceptional cleaning service every item of clothing labelled in (resident) name".

**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 the actual and planned staff roster and from observation was satisfied that there was a sufficient number and suitable skill mix of staff on duty during the inspection to meet the needs of residents. However, on some days of the week this required improvement.

The roster read confirmed there were three nurses on duty from 8am until 8pm, with an additional clinical nurse manager twice a week from 8am to 5pm, plus up to 19 care assistant staff. However, on some days there were three nurses on duty during the day. Given the size and lay out of the premises and the dependency level of the residents this was not sufficient. The ratio of one nurse to 31 residents is considered low. The inspector was informed that at times during the day, two nursing staff were required to administer certain types of medicines, leaving one unit unsupervised. It was observed there was no nurse present to oversee the mealtime and the provision of modified consistency diets for residents. While there were no negative outcomes for residents were observed during the inspection, there is potential risk in respect of medication management and that residents are not been supervised by a nurse during meal times

There is on-call is available from the person in charge.

There was sufficient catering and household staff available who were knowledgeable on their respective responsibilities and duties.

A review of four personnel files demonstrated that the provider had ensured the information required to be kept as per Schedule 2 of the regulations was in place. The current registration numbers for all nursing staff were available and up-to-date.

An examination of the training matrix demonstrated that there was a commitment to on-going mandatory training and other training pertinent to the needs of the resident population. All staff had up-to-date mandatory training in fire safety and management, and the protection of vulnerable adults. Training was provided in the movement and handling of residents, infection control and dementia care.

Additionally training had been provided in food and nutrition, end-of-life care and expressive behaviours was completed by all nursing staff. The training records were supported by documentary evidence such as sign in sheets and certificates.

There was an induction plan in place for new staff of various roles to ensure they were familiar with the procedures and with residents care needs. Probationary periods were undertaken and recorded. The person in charge completed annual appraisals with all staff. Supervisory responsibilities were allocated each day with key roles for the nursing staff and the care assistant staff.

A number of external service providers provided a valuable service to residents in the centre. There was evidence of vetting by An Garda Siochana and a written agreement of their role in the centre.

**Judgment:**  
Non Compliant - Moderate

### **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:***

Deirdre Byrne  
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>	Cairn Hill Nursing Home Bray
<b>Centre ID:</b>	OSV-0000755
<b>Date of inspection:</b>	28/06/2016
<b>Date of response:</b>	10/08/2016

### Requirements

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

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

### Outcome 02: Governance and Management

**Theme:**  
Governance, Leadership and Management

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

The implementation of recommendations and actions from audits required improvement.

The regularity of medication management audits requires review.

#### 1. Action Required:

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



Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

A comprehensive review of the Quality Improvement Plans arising from 2015 audits was undertaken in advance of the Annual Quality & Safety Review meeting on 06/01/2016. All QIP's documented during 2015 had been closed out by the year end. The QIP's for 2016 will be actively monitored at the monthly meetings to ensure follow up and close out.

The Person in Charge has implemented a clinical audit schedule for 2016 which includes planned monthly scheduled audits to include KPI's, medication management, restraint and infection control. The outcomes of these audits will be discussed at the monthly Clinical Nurse Manager meetings to identify trends, agree on quality improvement plans and to ensure actions/QIP's are implemented and closed out on an ongoing basis. The outcomes will be communicated to the monthly nurses' meeting.

The standard agendas for the monthly Clinical Nurse Manager's meetings and monthly Nurses' meetings have been amended to include discussion of KPI's and any decisions / actions to be taken in relation to residents and clinical risk. The minutes of these meetings will be presented by the Person in Charge at the monthly Management Team Meeting.

**Proposed Timescale:** 29/07/2016

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

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

The implementation of the National Policy in terms of bedrails requires improvement.

The assessment process for bedrails did not consistently include the alternatives considered.

There was inconsistent evidence of monitoring of bedrails when in use.

**2. Action Required:**

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

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

The Person in Charge has completed a comprehensive review of all residents on bedrails. All residents assessed as requiring bedrails have had alternatives to the use of

bedrails documented on their assessment.

Clinical Nurse Managers will undertake a monthly audit of restraint usage to ensure bedrail use is monitored and the guidelines applied as per National Policy.

On an ongoing basis, both nursing and care staff will continue to monitor the day to day use of bedrails. There are twice daily scheduled safety checks at 2.30pm and 2.30am whereby the Nurse on Duty and Senior Carer check all residents. Part of the checklist includes ensuring that appropriate measures are in place as per resident risk assessments e.g. the use of bedrails / restraint measures / falls prevention measures. Active monitoring ensures that appropriate safety measures are implemented and also informs whether such usage requires review. For residents who are at high risk of falls, additional supervision logs are implemented (every 15 / 30 minutes depending on level of risk). This log is completed by care staff and includes checking that relevant falls prevention measures are in place including restraint measures. Additionally care staff routinely check residents on restraint and update the restraint/release record accordingly. A falls prevention team meeting is held once a month with the multi-disciplinary involvement of the Person in Charge, Clinical Nurse Managers, Physiotherapists and a Senior Carer from each floor. The participants discuss falls from the previous month and actively review falls prevention measures (including restraint) and the appropriateness of their use.

**Proposed Timescale:** 29/07/2016

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

### **Theme:**

Safe care and support

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

Staff were not fully aware of the procedures to be followed in the event of a fire.

### **3. Action Required:**

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

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

As reported, appropriate measures were actioned immediately:

- A simplified fire safety notice was created and displayed at each nurses' station;
- Weekly fire drill was enhanced to include additional education for staff;
- A new fire drill record was created to be used at the weekly fire drills;
- Future drills will be scheduled at different times to capture staff working different shifts.

Furthermore:

The Emergency Plan and policy on fire safety have been amended to incorporate

subject changes, after liaising with the contracted fire safety consultancy firm.

**Proposed Timescale:** 28/06/2016

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

**Theme:**

Safe care and support

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

The maximum dose of PRN medication was not consistently prescribed for some residents'.

**4. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

The Person in Charge has liaised with the centre's Pharmacy provider and consultant GP. Pharmacy has agreed to ensure that the maximum daily dose of PRN medication will be documented on future drug kardexes, as transcribed by the GP.

Pharmacy have streamlined the medication administration sheet (MAR's) to ensure that only one template is in usage for residents. The current MAR's sheet documents the administration time (in 24 hour clock) rather than generic phrases such as 'breakfast, lunch, dinner'.

CNM's to conduct monthly medication audits to monitor adherence to medication management best practice.

**Proposed Timescale:** 29/07/2016

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

**Theme:**

Effective care and support

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

There was inconsistent evidence that residents or their next of kin were consulted in the review of their care plan on a regular basis.

**5. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding

4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Nursing staff have been educated to ensure that resident and family communications regarding care plan updates are consistently documented in the 'Family Communications' section in the electronic records system to reflect ongoing practice.

**Proposed Timescale:** 29/07/2016

**Theme:**

Effective care and support

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

Some care plans did not consistently guide the care to be delivered to residents. For example, management of responsive behaviours, risk of wandering, falls prevention, epilepsy/seizure care, diabetes management and weight loss.

Some care plans were not developed for all residents' identified need. For example, wound care.

**6. 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:**

The Person in Charge undertook a review of all care plans addressing wound care, management of responsive behaviours, risk of wandering, falls prevention, epilepsy/seizure care, diabetes management and weight loss. Any updates required have been actioned. Clinical Nurse Managers to undertake monthly care plan audits going forward to monitor compliance.

Actions have been communicated to staff nurses at their monthly meeting.

**Proposed Timescale:** 29/07/2016

**Theme:**

Effective care and support

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

The management of wound care in the centre required improvement.

**7. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident,

including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

A wound care plan was created for the identified resident and submitted to the Authority on 04/07/16. The Person in Charge has undertaken a review of all Residents with wounds to ensure that a care plan is in place which reflects the wound care management plan for the subject residents. Wounds are re-assessed after every change of dressing. Wound care plans are updated quarterly or more frequently if required.

Actions have been communicated to nursing staff at their monthly meeting. Clinical Nurse Managers to audit care plans on a monthly basis to monitor compliance.

**Proposed Timescale:** 04/07/2016

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

The staffing skill mix and number on certain days of the week requires review.

**8. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

The Registered Provider will provide additional nursing cover from 9am until 5pm on Saturday and Sunday to ensure that there is supernumerary nursing cover. This additional 'floater' nurse will provide support to the nursing staff on each floor for example, to assist the duty nurses in co-signing high alert medications, to cover breaks, to assist in the case of emergencies etc. Supernumerary nursing cover is already available from Monday – Friday with the roles of the Director of Nursing and Clinical Nurses Managers providing additional support as required. An Assistant Director of Nursing will also commence in the role early September 2016 to provide additional support to the clinical management team.

The nurses' daily routine has been amended to ensure that nurses are present to oversee mealtimes and the provision of modified consistency diets; medication rounds (which previously took place during this time) will commence after the service of modified consistency diets have completed.

**Proposed Timescale:** 01/09/2016

