

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Bray Manor Nursing Home
Centre ID:	OSV-0000018
Centre address:	47 Meath Road, Bray, Wicklow.
Telephone number:	01 286 3127
Email address:	braymanor@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Barravore Limited
Provider Nominee:	Shay Costello
Lead inspector:	Nuala Rafferty
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal 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:
23 May 2017 09:30	23 May 2017 19:00
24 May 2017 09:00	24 May 2017 18:00

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

Outcome	Our Judgment
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	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
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	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an announced inspection further to the receipt of an application to renew the registration of the centre. The inspection took place over two days. Prior to the inspection the provider was requested to submit relevant documentation to the Health Information and Quality Authority (HIQA).

The provider entity and person in charge demonstrated adequate knowledge of the

Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland 2016, in relation to their roles and responsibilities.

As part of the inspection process, the inspector reviewed the documentation submitted, ascertained the views of residents, relatives, and staff members, observed practices and reviewed records as required by the legislation. Feedback from residents and relatives during the inspection was positive and complimentary with comments on the timely and patient response by staff to residents' needs.

Residents had access to medical officers and allied health professionals, such as physiotherapy and, speech and language therapists, and access to community health services was also available. Some improvements were required, including improvements to fire safety, risk management, care planning and assessment.

The action plan of this report highlights the matters to be addressed and also identifies where issues require to be addressed, related to the premises which did not fully 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 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland 2016.

The action plan response, submitted by the provider to some of the required actions, did not satisfactorily address all of the failings identified in the report. As some of the responses were not acceptable, HIQA have taken the decision not to include these responses.

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

Outcome 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:

A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the Regulations.

The statement included details on the organisation structure, staffing levels, and the ethos and philosophy of the service. In addition the document clearly outlines the basis on which rooms are allocated and linked to residents' identified needs. In particular the document informs prospective residents and their families that accommodation to the upper floors of the centre is based on the ability of each resident to safely use a chair lift and that this is regularly reviewed. Where a resident is assessed as no longer able to safely use the lift, the provider reserves the right to transfer a resident to accommodation on the ground floor, based on clinical need.

Copies of the document were available in the centre.

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):

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

Findings:

Actions were required from the inspection in January 2016 to ensure appropriate responses to detect, manage and prevent further spread of communicable and or transmissible diseases. Evidence of appropriate healthcare management and delivery of safe and suitable care was found and is detailed under outcome 11 of this report.

A clearly defined management structure that identified the lines of authority and accountability as outlined in the statement of purpose was in place. This service is family owned and operated. The provider entity also operates a second centre in the northwest. The person representing the provider entity works full time in the centre as part of the management team and also works in a clinical nurse manager capacity, when required. The management team also included the person in charge and full-time clinical nurse manager. Shared supports with the second centre included administration staff and the director of services.

Some systems were in place to monitor quality and safety of care. Data was being collated on a weekly basis on key performance indicators (KPIs) of clinical care such as: restraint, infection prevention and control, complaints, meals, and moving and handling. These KPIs are used as a way to assess the standard of care being delivered in the centre. Regular meetings of the senior management team took place and a sample number of minutes of these meetings were viewed. The inspector was told that the management team considered the data collated on the KPIs and used this information to identify actions to improve the standard of care delivered to residents. However, there was limited documented evidence of data analysis, or that the results of all audits were used to promote improvements in care standards. Improvements to these care monitoring systems were required to establish a complete cycle of audit. This was discussed with the authorised person for the provider entity, the service director and person in charge during the inspection and at the feedback meeting.

Findings of this inspection, reflected under relevant outcomes in this report, identified where other improvements to governance processes were required. In particular, where risk management and clinical risk assessment processes, were not adequate to ensure residents' safety in relation to the use of chair lifts, and safe evacuation in the event of an emergency. Improvements were also required in areas of care planning, assessment and review of residents needs.

An annual review of safety and quality of care was conducted and a copy of the report was provided subsequent to the inspection. The report included information on areas such as: staff training, recruitment procedures, complaints and management processes. It also identified some areas where improvements are planned. The report included an undertaking to consult with residents and their relatives on future service developments and to undertake a satisfaction survey. However, it did not identify whether this review was prepared in consultation with residents or their families.

Judgment:

Non Compliant - Moderate

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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 centre maintained a residents' guide which described the facilities and services provided by the centre and a copy was available for each resident. The guide included information such as advocate access and the complaints procedure. A notice board was displayed beside the stairway in the ground floor hallway that informed residents and relatives on the activities for that day, staff on duty, weather and menu for the day.

Each resident had a written contract of care signed in agreement with the provider which stated the regular fee payable, the resident's contribution and the services to be provided under that fee. The contracts of care also outlined the terms of residency including whether the room to be occupied was a single or shared room.

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 centre was managed by a suitably qualified and experienced nurse who held authority, accountability and responsibility for the provision of the service .Through an assessment process it was noted that there was daily engagement in the governance, operational management and administration of the centre. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions.

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 centre maintained a suite of policies including those required under Schedule 5 of the regulations. Policies were reviewed on a regular basis and within the three year timeframe required by the regulations. General records, as required under Schedule 4, including appropriate staff rosters, nursing and medical records were also in place. A directory of resident was in place and contained complete information on the residents, their next of kin and their general practitioners(GP's). The directory was up to date with records of admissions, discharges and transfers maintained.

The statement of purpose, residents' guide and insurance certificate was complete and available.

Documentation of testing and servicing of fire safety equipment and assistive technology for residents such as hoists and specialised chairs was viewed.

The centre kept a log book of visitors coming and going from the centre.

It was found that all records listed in Schedule 2 and Schedule 3 of the regulations were being maintained in terms of accuracy and were updated regularly. The inspector reviewed a sample of staff files and found that they met all of the requirements listed in Schedule 2.

However, the fire safety management policy recently revised was not fully implemented. The inspector acknowledges that staff had only received one training session, however, findings detailed under outcome 8 of this report identify where improvements were required to ensure the policy and procedure are fully implemented.

Judgment:

Substantially 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:

Suitable arrangements were in place for periods of absence of the person in charge. The fitness of the clinical nurse manager to replace the person in charge in the event of an absence was determined through observation and discussion during the inspection. The clinical nurse manager had the qualifications and experience required by the legislation and was previously the person in charge in the centre.

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):

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

Findings:

Actions were required from the last inspection in January 2016 to improve the transparency and security of the systems in place to assist residents with the management of their finances. This related to determining residents' capacity to give consent and incomplete documentation of processes or accounting methods. These were found to be fully addressed on this inspection.

The provider assisted a very small number of residents with their finances.

On a sample of records viewed it was found that residents' cognition was assessed prior to or on admission to the centre and regularly reviewed.

Improvements to the systems in place and completeness of records were also found. A client account, separate to the overall business, was in place and all the resident's

monies were lodged into their account prior to fees been charged. Bank statements were provided to residents on a regular basis and there was evidence of residents' involvement in their financial affairs.

Staff had received training on the prevention of elder abuse and all staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms of, and responding to and managing abuse. Procedures to protect residents, such as a robust recruitment system, staff induction and training were also in place and implemented.

In conversations with them, residents told the inspector that they felt safe and secure in the centre and relatives also confirmed that they did not have any concerns for the safety of their loved ones.

Assessment of risks, associated with the use of restraints such as bed rails and lap belts, were in place and regularly reviewed. Falls management systems included appropriate supervision of residents by staff, and incident and accident records indicated a low falls rate.

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 inspector reviewed the fire safety management practices in place, including some aspects of the physical fire safety features of the building. Records for maintenance, fire safety training of staff and policies and procedures relating to fire safety were also viewed.

Emergency lighting, fire-fighting equipment, and directional signage were available throughout the building. The internal and external premises and grounds of the centre appeared safe and secure, with locks installed on all exterior doors. A health and safety statement and related policies and procedures were in place. Risk registers were also in place. These included clinical risks, health and safety and fire risk registers. However, all risks related to fire were not included on these registers, in particular, the lack of alternative means of escape from the upper floors for all residents.

Issues found on the inspection included:

-The inspector observed that there were areas, on the upper floors of the centre, where a single protected stairway was the only means of escape available. The inspector found that there were risks associated with the accommodation of some residents, on the

upper floors of the centre, who were immobile or had reduced mobility. The inspector found that these risks were not fully assessed. This was brought to the attention of the provider during the inspection. The provider undertook to manage these risks in discussion with residents and their families. The provider subsequently notified the inspector on the day immediately following the inspection that some of these residents were transferred to the lower ground floor, but that other residents did not wish to be transferred. The provider was informed that these risks required regular review and risk assessment to ensure that safe evacuation procedures were in place and were fit for purpose.

-Inconsistencies were found between the bedroom numbers on the emergency evacuation plans displayed in the centre and those on the bedroom doors. This may cause undue delay when carrying out the evacuation of residents in the event of an emergency. The provider has subsequently advised that this anomaly has been corrected.

- Personal emergency exit plans (PEEPs) that identified residents' level of mobility, the numbers of staff required to assist them, and the method of evacuation for each resident were in place. The plans also included issues that may affect the residents' level of cooperation with evacuation such as, anxiety or sensory impairments. Most staff spoken with, although not all, were familiar with these plans but the inspector found that there were different interpretations of these plans across the staff team. The inspector spoke with a number of staff and management and found that they differed in their interpretation of the plans on the method of evacuation to be used, in the sample of residents plans discussed with them.

- On the days of inspection a nurses' station was situated on the corridor between the bedrooms on the middle floor. This is a recurrent non-compliance and was included as an action in the last inspection report. The inspector noted that the location of the station between two fire compartments presented a risk to the safe evacuation of residents. The inspector noted that there was a high throughput of people on this corridor. Risks associated with this location included: limited circulation space, maintaining clear walkways on all corridors leading to fire exits, lack of confidentiality of residents' data and impact on residents' dignity while using the communal shower and toilet were again identified to the provider. The inspector discussed this with the provider, who subsequently notified the inspector that this station has been fully re-located.

A fire safety management procedure and fire safety information policy was in use in the centre; however, the procedure was not fully implemented in that:

- The procedure states that where final exit escape routes were operated by key, all staff should carry a key. Break glass units with keys were located adjacent to the exit doors and adjacent to a padlocked gate located to the side of the building. This gate was identified as the main entrance to be used for admitting emergency services. However, it was noted that only the maintenance staff had the key on their person and of those staff spoken with, some were not aware of the location of some of the break glass units.

- Arrangements for fire safety training to be provided to staff were in place and the inspector was told that the response by staff to fire alarm activation was regularly spot checked and practiced. A revised fire safety management procedure and fire safety information policy was recently introduced in the centre. Staff training had commenced and most staff had recently attended the first training session in the new procedures.

This training included a simulated evacuation drill. A record of the evacuation drill training identified that it included minimum staffing levels. However, the record also showed that the drill reflected the evacuation of one resident only and did not show whether all residents in a specific compartmented area could be safely evacuated within a reasonable time-frame and when staffing levels are lowest. It was found that simulated fire drills were not previously recorded. The provider has since advised that further simulated practice drills have taken place.

-Documentation was viewed which stated that an assessment of the fire detection and alarm system was required in 2015. The provider gave verbal assurances during the inspection that this was addressed and forwarded evidence subsequent to the inspection.

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:

Written operational policies were in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents.

Medicines were supplied to the centre by a retail pharmacy business in an individual monitored dosage system. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

Nursing staff were observed administering medicines to residents during the lunch time administration rounds. The administration practice was in line with current professional guidance.

Judgment:

Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

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

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):

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

Findings:

The findings of the last inspection required actions to improve care planning and assessment processes to make them more specific and ensure they meet residents' needs. On the last inspection it was found that the care plan system was not sufficiently detailed to guide staff and assessments were inadequate. These findings were recurrent on this inspection.

Evidence of referral and review by a range of medical and allied health professionals was found with documented visits, assessments and recommendations by dietitian, speech and language therapists and physiotherapy reviews.

Samples of clinical documentation including nursing and medical records were reviewed. These showed that all residents were assessed prior to initial admission to the centre. Transfer of information within and between the centre and other healthcare providers was good. Discharge letters for those who had spent time in acute hospital and letters from consultants detailing findings after clinic appointments were maintained.

Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. Samples of these clinical records were viewed. Some improvements were required to to the standard of clinical documentation and assessment of care needs to ensure the full needs of all residents were met in a holistic manner. The inspector found that some identified risks, associated with the activities of daily living were not fully assessed. These included activities such as showering and use of mobility aids such as chair lifts. Care plans were not in place to guide staff on the management of symptoms associated with some clinical conditions such as Parkinson's Disease. Where care plans were in place, they were found to contain the minimum information required to manage the health problem. The information was general and not person centred. Examples included:

- Some care plans that guide staff on personal care preferences were not updated to reflect deterioration in the residents' condition and current inability to avail of showers or baths.
 - Some care plans in place to manage the problems associated with deteriorating mobility were viewed. These did not guide staff practice on all appropriate forms of assistance to be provided to the resident. In particular, they did not reference the need for assistive equipment such as chair lifts. This created potential risks for the provision of safe care to residents on the upper floors, the majority of whom used chair lifts to access the communal areas in the centre.
 - Some care plans in place to manage pressure area care for residents spending long periods of time in bed or chairs were viewed. These did not reference the frequency of re positioning required to manage the need or the requirement to provide opportunity for movement with passive or active exercise to maintain or promote blood flow and muscle tone.
 - Activity care plans were not linked to residents' life stories to ensure that activities provided were meaningful or linked to their past interests.
- Additionally, it was noted that the reviews of care plans did not consider the effectiveness of the interventions to manage and or treat the need.

Aspects of other clinical documentation required improvement to ensure they were clear and coordinated. Nurses' daily progress records did not provide enough detail on the overall status of residents. The notes did not always comment on the care delivered, signs of improvement or deterioration in physical emotional or psychological state. They did not always indicate how the resident had spent their day. This meant that a general picture of each person's overall health and wellbeing could not be determined.

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

Theme:

Effective care and support

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

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

Findings:

Actions were required from the last inspection and these were found to be partially addressed on this inspection. Actions that were addressed included: repair or replacement of automatic door closures and highlighting of all floor gradient changes. Actions not addressed included the re-location of the nurses' station on the middle floor.

The design and layout of the centre was broadly in line with the statement of purpose. This nursing home was not purpose built, and consists of a converted former Georgian house with accommodation provided over three floors, and a chair lift to transfer residents between the floors. The provider has applied to renew registration with a capacity of 23 persons.

The centre currently consists of 11 single, four twin and one three bedded bedrooms, most with en suites, although only two have full shower en suite. The bedrooms are located on each floor of the centre. The ground floor has seven single and one twin bedroom. The middle floor has four single bedrooms and the top floor has three twin and one three bedded room. The multi-occupancy room was spacious with adequate screening for privacy. The centre was found to be well maintained, warm, comfortably and tastefully furnished and visually clean. The inspector observed that most residents' bedrooms were personalised with items including photos and paintings.

Communal facilities were available on the ground floor including a bright sitting room; visitors' room, and a conservatory with access to a small enclosed patio area. Grab-rails and handrails were installed where required. There was a functioning call-bell system in place within the centre, and hoists and pressure relieving mattresses were in working order, with records available to indicate servicing at appropriate intervals. There were magnetic automatic door closures, linked to the fire alarm system, attached to doors throughout the centre. The provider had recently refurbished the dining room and renovated a twin room to provide two single bedrooms on the middle floor.

A small secure garden was available for use by residents to the rear of the centre, with a designated smoking area. The garden contains shrubs and plants and safe walkways. However, the inspector identified a number of areas where the premises required to be improved to meet the needs of current and future residents, and the requirements of the legislation and national standards for older people by 2021. These included:

- Shower or bath and toilet facilities did not meet the needs of all residents. The top floor does not contain a communal shower or bathroom and two bedrooms on the top floor did not contain a full shower en suite

- Size limitations of current en suites and communal shower rooms meant none were large enough to facilitate the use of assistive equipment such as shower trolleys, for

residents requiring this type of equipment. The inspector learned that some residents were unable to sit upright even with the assistance of staff and the use of shower chairs posed potential risks. Shower trolleys or similar assistive equipment was not available for use.

- The inspector noted that the centre had limited storage space. Hoists, wheelchairs and specialised seating were stored in residents' bedrooms.

- Further improvements to signage and way-finding for residents with dementia through picture or colour cueing of bathrooms and bedrooms was required. The function of all rooms in the centre was not identified and room numbers were not in place on all bedroom doors.

- The nurses' station on the corridor on the middle floor required to be re located. This is a recurrent finding from the previous inspection.

Systems to monitor water temperatures and regular water sampling to prevent risks associated with legionella disease were not in place, however, the provider took immediate steps to address this and evidence that this was addressed, was provided to the inspector prior to the end of the inspection. The provider contracted a recognised external environmental service to commence quarterly sampling the water supply and provide cleaning and disinfectant techniques if required.

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:

Policies and procedures which comply with legislative requirements were in place for the management of complaints. Residents were aware of the process which was displayed in the centre..

On review of the record of complaints there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

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:

Adequate equipment and facilities for residents and relatives were available to meet religious and spiritual needs.

A determination on the standard of end-of-life care delivered could not be fully made as no resident was receiving end-of-life care at the time of the inspection.

Access to specialist palliative care services was available when required.

The inspector looked at the systems in place to manage end-of-life or comfort care. On review of care plans in place it was found that the will and preference of the resident in relation to spiritual support, ceremony and funeral arrangements were sought.

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:

Residents were provided with food and drink at times and in quantities adequate for their needs. A rolling menu was in place to offer a variety of meals to residents.

Assistance was observed and was offered to residents in a discreet, patient and sensitive manner by all staff.

Most residents took their meals in the dining room and tables were appropriately set with cutlery, condiments and napkins. Residents spoken with all agreed that the food provided was always tasty, hot and appetising. The main kitchen was located beside the

dining room. Food was served directly from there by the chef and was well presented. Residents on modified consistency diets also received the same choice of menu options as others. Lists of special diets required by residents were available in the main kitchen. The inspector met with the chef who knew residents dietary needs and their likes and dislikes. Drinks such as water, milk, tea, coffee and fresh drinking water were available at all times .

Evidence of referral to relevant allied health professional including dietitian or speech and language therapists was found. There was a system in place to monitor the intake of residents identified as at risk of malnutrition, although the inspector was told no residents were identified as requiring same at the time of inspection.

Judgment:

Compliant

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

Theme:

Person-centred care and support

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

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

Findings:

Actions were required from the last inspection in January 2016 to improve opportunities for residents to participate in community-based activities and outings. At that time, purposeful or meaningful activities for all residents with deteriorating physical and cognitive abilities and or limited mobility on a one-to-one basis were also limited. These actions were not addressed and are recurrent findings on this inspection.

Evidence that residents were consulted with and participated in the organisation of the centre was found. The inspector spoke with a number of residents and learned that resident forums were held usually quarterly and were chaired by an independent advocate. Suggestions made by residents were taken on board by the provider and actioned. The inspector was told that one resident was the nominated spokesperson for all residents. This person told the inspector that there were regular meetings with the person in charge and the provider to discuss issues of concern for the resident group. Residents spoken with believed their rights to privacy and dignity were respected, they felt very involved in their own care and believed they were treated as independently-minded people with the right to self-determination and choice.

Appropriate and respectful interactions were observed throughout the day between residents and staff who respected residents' dignity and choice during care interventions and in their daily routine. Staff were observed to assist most resident's with their activities of daily living such as washing, dressing and eating. The assistance was provided in a low-key but warm and unhurried manner.

The inspector was told that residents were enabled to vote in national referenda and elections with the centre registered to enable polling. Access to advocacy services was available and contact details for advocacy services were displayed.

An activities programme was in place delivered by an activities coordinator each day. It included a mix of activities, intended to stimulate residents both physically and mentally, such as: arts and crafts, cards, scrabble, fit for life exercise sessions, dog therapy, music and baking. Dementia relevant activities were also included in the programme such as reminiscence. All activities took place in the ground floor sitting room. However, the activity programme was not fully linked to the information gathered in the form of residents' life stories in order to include purposeful activities linked to their former interests or lifestyles.

As part of their role, the activities staff supervised residents in the sitting room throughout the day. This limited the time available for individual one-to-one activities, although the inspector found that there were some residents who spent a lot of time in their bedroom due to frailty or choice. The inspector learned that these one-to-one activities, such as hand massage, reading or conversation sessions were usually delivered between 1 and 1.30 pm daily. They would typically last for approximately five-to-10 minutes depending on the engagement and interest of the resident. This meant that staff could spend time with up to four residents on an individual basis per day. The inspector observed that for the most of the day these residents relied on the T.V. or radio for stimulation.

Opportunities for residents to avail of external outings remained very limited. External outings did not form part of the core activity programme and the inspector was told by both staff and relatives that residents relied on their families to take them out. Some efforts to improve this recently were noted where one resident was brought out shopping by staff and the provider was in the process of organising a trip to Powerscourt town centre in the coming week. However, regular access to the community such as walks to the seafront, going for coffee or meals out was not facilitated for most residents. It was also noted that opportunities for residents to attend religious services such as Mass were limited. The inspector found that residents' religious needs were met primarily through bi-weekly visits from Eucharistic ministers who also facilitated prayer meetings. However, Mass was not celebrated in the centre, despite efforts by the provider to do so. Residents relied on watching Mass on the national TV station, unless family or friends could bring their loved ones to the local church in the village.

Judgment:

Non Compliant - Moderate

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:

There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents.

All clothing was labelled for the laundry, and new clothes were added to an initial list by staff.

There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents.

All clothing was labelled for the laundry, and new clothes were added to an initial list by staff.

There was adequate space provided for residents' personal possessions, and it was noted that clothing was stored in a neat and appropriate manner.

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:

Suitable and sufficient direct care staffing and skill mix were found to be in place to

meet the needs of the current resident profile.

The staff rota was checked and found to be maintained with all staff that worked in the centre identified.

Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place. Cover for planned and unplanned leave was provided within the current staff complement.

Records reviewed showed that staff had been provided with opportunities to receive updated training in areas such as: safeguarding, moving and handling, fire safety, first aid, dementia care and food hygiene. Attendance records were also viewed.

Appropriate and respectful interactions were observed throughout the day between residents and staff. Overall, it was noted that residents' dignity and choice was respected during care interventions and in their daily lives.

A formal staff appraisal system was established that discussed the continuous performance and training of staff with each staff member.

Effective staff supervision and development processes were in place and team working was strongly evident. Good recruitment processes were in place including a Garda Síochána (police) vetting process. Identity checks were also conducted for all overseas staff recruited. The inspector verified that all nurses were registered with the Irish Nursing Board.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Bray Manor Nursing Home
Centre ID:	OSV-0000018
Date of inspection:	23 & 24 May 2017
Date of response:	17 July 2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Evidence that the annual review was prepared in consultation with residents or relatives was not identified .

1. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

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

We have regular Meetings with Residents and Relatives, and their views and opinions are acted on, as is acknowledged in this report.

The Annual Review does not sufficiently reference this.

We will carry out Resident/Relative Surveys and review the report to include consultation with Residents and Relatives.

Proposed Timescale: 31/12/2017

Theme:

Governance, Leadership and Management

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

Some aspects of the management and governance systems in place were not fully effective to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

2. Action Required:

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:

The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The fire safety management procedure and fire safety information policy in use in the centre was not fully implemented in respect of key operated final fire exits, conducting and recording simulated evacuation drill training and interpretation of residents personal emergency exit plans, as identified in the body of the report.

3. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement

policies and procedures on the matters set out in Schedule 5.

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

A new, comprehensive Fire Safety and Emergency Strategy has been implemented and Staff were being updated.

All Staff now carry keys to the Fire Exits, in addition to the existing push cover units, located at each exit.

Prior to Inspection, all Staff had received Mandatory Training and completed an individual evacuation.

We have continued to engage a recognised Fire Safety and Training Company, to pre-assess and implement our Fire Management Plan. The results will be audited for effectiveness in September 2017.

The next Fire Training is scheduled for September. This will be an on-going process.

Evacuation Drills will continue to be held regularly and be un announced. Fire Drills have always taken place regularly and while recorded, were not timed.

The Fire Drills will now always include timed evacuation drills.

Proposed Timescale: Completed and On-going.

Proposed Timescale: 17/07/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The arrangements in place for fire safety management did not identify risks associated with the profile of residents on upper floors of the centre where only one means of escape were available, and where some residents were not fully mobile.

It was not demonstrated that a compartment could be evacuated, in a timely fashion, either through progressive horizontal evacuation or via stepped escape routes, if required, at times when staffing levels are lowest.

4. Action Required:

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

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

The action plan submitted by the provider, for this action was not acceptable to HIQA, as it did not satisfactorily address all of the failings identified in this outcome of the report.

Proposed Timescale:

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:

Reviews of care plans did not include a determination of the effectiveness of the plans to meet the needs identified. The documentation of care did not provide a clear picture of residents' current condition.

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:

All Resident's have a range of assessments and care plans, that are reviewed regularly and as the resident's condition changes.

We are currently reviewing all care plan documentation and examining each domain from assessment to care planning to evaluation, to ensure that our documentation provides a clear picture of all residents' current conditions & nursing interventions, aimed at ensuring optimal quality of life.

Our team are very familiar with each residents' needs and have a warm relationship with each of them. Our documentation is not sufficiently reflecting this or guiding Staff sufficiently.

We are providing further training to staff and will conduct audits to review progress in the coming months. Care planning will reflect the ongoing communication and input we have with families and significant others at Bray Manor.

Proposed Timescale: 31/10/2017

Theme:

Effective care and support

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

Complete comprehensive clinical risk assessments were not carried out for each resident in respect of every identified need.

6. 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:

Pre-admission assessments have been carried out prior to admission by the Provider Nominee (who is a Registered Nurse), or the Person in Charge without exception.

A full range of accredited assessment tools are used, such as the Mandatory EWS, Bartel Index, Waterlow. This is completed in Epic-Care.

We are reviewing our pre-admission documentation, to ensure it is comprehensive enough to identify each need and nursing intervention necessary, to enhance optimum quality of care & life for each Resident.

Proposed Timescale: 31/10/2017

Theme:

Effective care and support

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

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently meet the identified need.

7. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

All Resident's have full range of Mandatory Assessments completed and reviewed within recognised time-frame.

We are reviewing all currently used, accredited risk assessments, to ensure they are used effectively to assess each Resident's needs and that risk assessments are reflected in Care-Plans. This process has been commenced and is in place, with regard to Skin Integrity/Pressure Area Care.

We acknowledge that overall documentation in certain cases, may not reflect all Residents needs, and may not guide Staff sufficiently.

We have commenced further Training for Staff, to guide improvement in documentation.

We are examining each domain, from Risk Assessment to Care-Planning, to Evaluation, to ensure that the Person-Centred Care provided in Bray Manor is reflected in our documentation.

We will be auditing progress, to ensure compliance is reached and maintained at all times.

Proposed Timescale: 30/09/2017

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:

The premises did not fully meet the requirements of the regulations as set out in Schedule 6 in that:

Shower or bath and toilet facilities did not meet the needs of all residents. The top floor does not contain a communal shower or bathroom and two bedrooms on the top floor did not contain a full shower en suite

Size limitations of current en suites and communal shower rooms meant none were large enough to facilitate the use of assistive equipment such as shower trolleys, for residents requiring this type of equipment. Shower trolleys or similar assistive equipment was not available for use.

Storage space was limited and some equipment was stored in residents' bedrooms. The nurses' station on the corridor on the middle floor required to be re located due to risks associated with its' current location. This is a recurrent finding from the previous inspection.

8. 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:

Two en suite showers will be fitted to bedrooms on the top floor.

Plans are in place and work ready to commence to build a Wet-Room, large enough to facilitate a shower trolley on the ground floor.

Any resident unsuitable for use of the chair lift and most likely requiring assistance of a shower trolley or similar assistance equipment, can be accommodated on the ground floor. This work has now taken place and will be available from 17th July 2017.

Work has now been completed on a new storage area to accommodate assistive equipment.

The nurses station has been removed from the middle floor.

Proposed Timescale: 01/12/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Opportunities for residents to avail of religious services within the centre or in the community and access to the community for social interaction or events were limited.

9. Action Required:

Under Regulation 09(3)(c)(iv) you are required to: Ensure that each resident has access to voluntary groups, community resources and events.

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

We actively encourage all Resident's to access Community Groups and Events.

We encourage Residents to avail of the amenities in the Locality and facilitate those who wish to do so, when required.

Opportunities for Resident's to avail of Catholic Mass within the Nursing Home, is limited due to the unavailability of a Priest to say Mass.

Prayers are said daily and Communion is brought to Residents twice weekly.

Mass is broadcast live on TV daily, as well as Prayer Service being held on Friday and Monday's, which is facilitated by Volunteers from the Parish (as was discussed with Inspector).

Ministers for all other Religions attend on a regular basis.

We consistently try to provide Mass and this will be an on-going effort.

We are undertaking a full review of our Activities Programme, to enhance access for Resident's to external Groups and Events in the Community and to facilitate more Social and Family Events within the Nursing Home, for example, Family Fun Days.

We have invited several Voluntary Groups to the Nursing Home.

A Schedule of Events will be decided with Resident's and Relatives in the coming weeks,

to include external and internal Activities.

Proposed Timescale: 31/10/2017

Theme:

Person-centred care and support

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

Opportunities were limited for purposeful or meaningful stimulation for all residents who remained in bed or in their bedrooms for long periods of time due to frailty or personal preferences

10. Action Required:

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

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

We have discussed this action with resident's concerned.

We are working with these residents who expressed strongly their preferences (which are care planned), to examine how we can offer/improve on meaningful stimulation, to enhance their quality of life, as they wish to have it.

In the case of those who have advanced conditions, the visits from family are included and recorded as activity.

Another resident is reluctant to engage with anyone, other than the next of kin and this is respected and also care planned.

We will examine overall systems in place, to offer meaningful activity & stimulation to all resident's, both internal and external, and we will audit this progress.

We will survey with residents and relatives to seek feedback/opinions/ideas, on how to improve this aspect of care.

We are committed to improving social Inclusion and activity, while respecting personal preference. A schedule of events, both in the nursing home and in the community, will be decided in conjunction with resident's and families over the coming weeks.

Time frame for completion;7/8/17

Proposed Timescale: 07/08/2017

