

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Cedar House Nursing Home
<b>Centre ID:</b>	OSV-0000023
<b>Centre address:</b>	35 Mount Anville Park, Goatstown, Dublin 14.
<b>Telephone number:</b>	01 283 1024
<b>Email address:</b>	cedarhouseadministration@eircom.net
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Cedar House Nursing Home Limited
<b>Provider Nominee:</b>	James Bergin
<b>Lead inspector:</b>	Leone Ewings
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	22
<b>Number of vacancies on the date of inspection:</b>	1

## 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:
08 February 2017 09:30	08 February 2017 16:30
09 February 2017 09:30	09 February 2017 14:30

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	Substantially Compliant
Outcome 02: Governance and Management	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	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This report sets out the findings of a two day inspection, the purpose of which was to inform a decision for the renewal of the centre's registration. A monitoring inspection which took place on 23 March 2016 will also be considered as part of the overall assessment of compliance. The provider had fully addressed the five action plans from the previous inspection, with improved risk management policy and procedures and staff training.

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

Surveys and questionnaires completed by residents and/or their relatives were also reviewed, this included feedback from four residents and eight relatives. Overall, the inspector found that care was delivered to a high standard by staff who knew the

residents well and discharged their duties in a respectful and dignified way.

The management and staff of the centre were striving to improve resident outcomes. A culture of person-centered care was observed. Residents appeared well cared for and expressed satisfaction with the care they received in the centre and confirmed that they had autonomy and freedom of choice. Residents spoke positively about the staff that cared for them.

Safe systems and appropriate measures were in place to manage and govern this centre. The provider, person in charge and staff team responsible for the governance, operational management and administration of services and resources demonstrated sufficient knowledge, governance and an ability to meet regulatory requirements.

The five action plans at the end of this report identify areas where improvements by the provider are required in order to fully comply with the regulations. These include staff and residents' records, staff training, health and safety and risk management and the statement of purpose.

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:**

An updated statement of purpose dated January 2017 was in place. This document detailed the aims, objectives and ethos of the service. The information was in line with legislative requirements. However, it required updating with details of the organizational structure.

The provider has been requested to submit this updated information to the Chief Inspector for review following the inspection.

**Judgment:**

Substantially 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:**

Management systems were in place to ensure that the service to be provided was safe,

appropriate to residents' needs, consistent and effectively monitored. The annual quality and safety review for 2016 had been drafted with feedback from residents which informed practices and quality of life at the centre.

There was a clear management structure in place as outlined in the statement of purpose. The management team included the provider who works as administration manager and the person in charge. The person in charge was supported by the provider who is available each day in the centre. A senior nurse assists the person in charge in managing clinical aspects of care and also deputises for her.

The inspector found there is a robust system in place to conduct audits. A review of the safety statement has taken place since the time of the last inspection.

The registered staff nurses reported to the person in charge or her deputy. The health care assistants report to the registered nurses. Staff turnover was low.

The inspector was informed that a schedule of clinical audits was implemented within the centre. The methods of obtaining feedback from any planned audits could be evidenced from the records reviewed. Clinical audits included hand washing, nutrition, falls and resident incidents. The centre operated a restraint-free environment in line with national policy.

Audits were also conducted to monitor the number of residents with weight loss, pressure ulcers and medicines management audit informed practice.

The inspector was satisfied that the centre is sufficiently resourced and the quality of care delivery was audited on a continuous basis

**Judgment:**  
Compliant

***Outcome 04: Suitable Person in Charge***  
***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The person in charge had not changed since the time of the last inspection, she is a registered nurse and works full time within the centre. The person in charge had been assessed previously by HIQA and she was deemed to have the required skills, knowledge and experience to hold the post of person in charge.

She was knowledgeable about each resident's nursing and social care needs. Evidence of her continuous professional development was up-to-date.

**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 records as listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness and accuracy.

Overall, a good standard of record keeping could be evidenced throughout the inspection, and records requested were accessible. Schedule 3 and 4 records were in place and in compliance with legislative requirements. One area for improvement was identified for the use of bedrail risk assessment documentation, where alternatives trialled were not fully evidenced in the records reviewed.

A sample of staff files were reviewed and found to contain all the requirements of schedule 2 of the regulations.

The centre was adequately insured against accidents or injury to residents', staff and visitors, as well as loss or damage to a resident's property.

A directory of residents was maintained which contained all of the matters as set out under regulation 19.

The designated centre had all of the written operational policies which had been recently reviewed as required by schedule 5 of the regulations. However, as outlined in outcome 7 aspects of the safeguarding policy relating to frequency of training required review.

**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:**

There were suitable arrangements in place for a nurse to deputise for the person in charge in her absence.

The provider has recently notified and was in the process of submitting the required information for a new deputy manager, participating in the management of the centre. The arrangements in place were found to be clearly outlined in the statement of purpose and confirmed on inspection.

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

**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 inspector was satisfied that safe systems were in place to protect residents being harmed or suffering abuse. There was a detailed policy to guide staff and they had received appropriate training in this area. Care and communication was observed to be person-centred and in an environment which promoted residents' rights. The person in charge was aware of the requirement to notify any allegation of abuse to the Authority.

Staff spoken to were knowledgeable of the different types of abuse and the reporting arrangements in place. The inspector spoke to a number of residents who said that they felt safe and secure in the centre. Staff were guided by a written detailed policy on the protection of vulnerable adults in place. Most staff had received safeguarding training on commencement of employment. However the inspector found 30 of the 40 staff employed did not have a record of up-to-date safeguarding training. The frequency of training was at variance with the policy, and risk assessments read by the inspector. The finding of this inspection was that the policy had not been fully implemented and required updating to reflect best practice. The person in charge confirmed that training dates had been identified with an external trainer, for staff training in the protection of vulnerable adults.

A policy on the management of responsive behaviors was in place that guided practice was in place. Supportive care plans were developed and in place to inform staff and guide practice where required. The findings were that evidenced-based tools were utilised to monitor behaviours. Staff were familiar with the residents and understood their behaviours, what triggered them and implemented the least restrictive interventions as outlined in the written care plan. Staff carefully considered and documented the rationale for use of any psychotropic medication. This area was subject to review.

The policy, practice and assessment forms reviewed reflected practice in line with national policy, as outlined in Towards a Restraint Free Environment in Nursing Homes (2011). The person in charge followed policy in that a comprehensive risk assessment took place and the least restrictive intervention was in use. Alternatives had been trialled prior to the use of any bed rails. The quarterly reports submitted by the person in charge could demonstrate that a small number bed rails were used, and an up-to-date risk register was in place. Evidence of the use of alternatives including the use of low-low beds and sensor mats were found. However, five residents were identified as using one bed rail on the their beds for safety, and in some instances by request of the resident. However, assessment documentation with alternatives trialled were not fully evidenced by the person in charge to support this approach, and required review as outlined in outcome 5 of this report.

**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):**

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

**Findings:**

Overall health and safety and risk management was found to be generally well managed. Improvements had taken place since the time of the last inspection. A safety statement dated April 2016 was up-to-date and informed staff and management in terms of mitigating any risks at the centre.

The inspector found adequate precautions against the risk of fire and that arrangements for the safe evacuation of persons from all parts of the centre were now in place. Fire safety works had taken place and the provider had sourced new door closers for some residents' bedrooms which allowed for accessibility and activated on an auditory signal from the fire alarm. The records confirmed that the fire alarm is serviced on a quarterly basis and fire safety equipment is serviced on an annual basis. The inspector found that all means of escape were unobstructed during the inspection. Staff confirmed to the inspector satisfactory knowledge of fire safety policy and actions to take in the event of a fire. The inspector viewed the fire training records and found that staff had received up-to-date mandatory fire safety training and this was also confirmed by the person in charge and provider. The fire safety policy and procedures were fully implemented in relation to the management of the fire safety at the premises.

The building and plans displayed near the main entrance and fire instructions were in place throughout the building. Staffs on duty were familiar with the evacuation procedures; including what actions to take in the event of a fire or evacuation and the relevant zones. The records of the fire drills which took place at the centre contained full details of the fire drill, and names of staff attending. The last fire drill took place on 24 January 2017 and a drill took place on average three times a year. All doors are checked weekly by a staff member, and the inspector saw evidence of emergency lighting maintenance.

The centre was observed to be clean and well maintained. The inspector found that there were measures in place to control and prevent infection. Training had been provided to all staff on infection control, hand hygiene and they had access to supplies of gloves, disposable aprons, and alcohol hand gels which were available throughout the centre. A separate dirty utility room was found to have all relevant equipment including a sterilizer. However, some equipment was inappropriately stacked and stored in an open cupboard where a wall-mounted drying rack was not in place. The person in charge agreed to action this. Staff training records confirmed that all staff had completed up-to-date moving and handling training.

An environmental audit programme which is over seen by the person in charge and provider was in place. Maintenance of the premises was found to be up-to-date, apart from one bath aid in an assisted bathroom which required repair or replacement and was out of use at the time of the inspection. The person in charge actioned this immediately and put a sign up to indicate that this equipment should not be used.

The person in charge had reported a small number of serious incidents as required by the regulations in a timely manner. This area was found to be well managed, and follow up with medical review and physiotherapy post falls was evidenced. There was evidence that staff took into account residents' right to independence and balanced this against

risks identified on assessment. However, the inspector found that two residents who smoked did not have a written risk assessment in place in line with the requirements of the policy. Although no immediate risks were evident, the arrangements around supporting both residents to undertake this activity were not clear. The provider and person in charge agreed to address this matter.

**Judgment:**  
Substantially Compliant

***Outcome 09: Medication Management***  
***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**  
Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Overall, medicines were found to be managed well, and safe practices were observed. Staff confirmed that a pharmacist from the retail pharmacy who supplied medicines to the centre was facilitated to visit the centre, and meet their obligations to residents as required by the Pharmaceutical Society of Ireland. Records reviewed by the inspector were maintained to a high standard. None of the residents currently self-medicated.

A new pharmacy provider had commenced supplying residents' medicines in a monitored dosage system, since the time of the last inspection. Nursing staff were familiar with all revised procedures for ordering, delivery, storage, and disposing of unused or out-of-date medicines. The medication prescription sheet contained details for prescribing for any crushed medications. Medicines management audits were conducted within the centre as part of the quality and clinical governance system in place.

Residents were protected by the centre's policies and procedures for medicines management. Medicines were stored securely in the centre, at the nurses' station in a trolley or within locked storage cupboards. A secure fridge was available to store all medicines, and prescribed nutritional supplements that required refrigeration. Fridge temperatures were checked and recorded on a daily basis.

Controlled drugs were stored securely within a locked 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.

The inspector observed nursing staff safely administering medicines to residents. The nurses on duty knew all the residents well, and were familiar with the residents' individual medication requirements. Medication administration practices were found to adhere to current professional guidelines. The rights and dignity of each resident

relating to taking their medicines were fully respected.  
The inspector reviewed a number of the records including prescription and administration sheets, and identified that practices conformed to appropriate medication management practice.

The inspector reviewed records which confirmed that all nursing staff had completed mandatory training in relation to medicines management.

**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 that each resident's wellbeing and welfare was maintained by a good standard of nursing care and appropriate medical and allied healthcare. There were also opportunities for residents' to engage in meaningful activity. Residents who spoke with the inspector were positive in their feedback about staff, and service provision.

The inspector saw that the arrangements to meet each resident's assessed needs were set out in individual care plans with evidence of resident involvement at development and review.

The inspector reviewed a sample of residents' health care plans which considered assessed need in relation to areas such as nutritional care, dental care, cognitive deficit, sleep patterns, skin care and wound management. Resident's could access medical specialists as required, for example plans evidenced recent visits to or by audiology, optician, physiotherapist, occupational therapy. Residents' had access to a General Practitioner as required. Resident's were also supported to maintain their own GP as requested, with four GP's visiting the centre regularly.

Staff used validated tools to assess levels of risk of deterioration, for example vulnerability to falls, dependency levels, nutritional care and cognitive impairment. There was evidence that care plans were reviewed every three months or more frequently if

required. For example, following the dietician reviews evidence of updates and specific details of care and food fortification and supplements were included.

Staff training relating to end-of-life care, journey of change and spirituality had been implemented. The inspector also observed that the food and nutrition policy was fully implemented, and residents weights were closely monitored by staff, and referrals made to dietitian or speech and language therapist where indicated.

Each resident had opportunities to participate in meaningful activity and the activity programme was based upon the residents' interests and hobbies. Residents confirmed they enjoyed various activities including daily mass, fitness class, and outdoor walks. Staff supported residents to maintain their involvement in their community and family members. For example, one resident was on holiday at the time of the inspection. In addition, other therapists were brought in to support the activities programme including music and complementary therapy.

**Judgment:**  
Compliant

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

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**  
Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that the layout and design of the physical environment met the needs of the residents to a high standard. The building is a purpose-built, single storey structure. The building is located in a suburban area of Dublin, with level access to mature landscaped grounds with safe pathways for walks. A reception area was located at the entrance to the building, an oratory, administration offices and clinical rooms were also in place.

The bedroom accommodation comprised 22 private single bedrooms and one twin bedroom. At the time of the inspection the twin bedroom was accommodating one resident. Ten of the single bedrooms had full en suite facilities comprising toilet, wash-hand basin and shower, while the remaining bedrooms had an en suite with toilet and wash-hand basin. A sufficient number of additional assisted bathrooms were also provided and a choice of bath or shower was available. The inspector visited a number

of bedrooms and found that they provided sufficient space and were clean and were all well maintained. Bedrooms were decorated and had been personalised with residents' possessions such as family pictures. There was a functioning call bell system in place and call bells were within easy reach of residents.

There was suitable and sufficient communal space for residents which included two sitting rooms, a library and two conservatory areas. The dining room was spacious and well organised in order to allow all residents to dine together. The dining area had level access to an outdoor sunny decked area. A sufficient number of assisted toilets were located close to the communal rooms. Grabrails and handrails were provided in all communal areas.

Appropriate assistive equipment was provided to meet residents' needs such as hoists, seating, specialised beds and mattresses. The inspector viewed the servicing records and maintenance records for equipment and found they were up-to-date. Appropriate arrangements were in place for the disposal of clinical waste and a separate, locked clinical waste bin was provided.

A high standard of hygiene and cleanliness was noted. Cleaning staff were working in an unobtrusive manner which did not disturb residents. Cleaning equipment was appropriately stored. The inspector spoke with cleaning staff and found that they were knowledgeable in relation to infection control and they described appropriate procedures such as the colour-coding of cloths and mops and safe procedures for cleaning in the event of an outbreak of infection. A dirty utility room was available for staff use and was equipped as outlined in outcome 7.

Separate changing facilities were provided for all staff.

**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:**

There was a complaints policy in place, no complaints had been recorded by the person in charge since the time of the last inspection in March 2016. Nonetheless, the inspector was satisfied that any complaints that occurred in the centre were listened to and acted upon. Suggestions and feedback was welcomed by the provider and person in charge.

At the time of the last inspection an active residents meeting took place and was a forum for any issues which were facilitated by the pastoral care worker. The person in charge confirmed that this meeting was temporarily not taking place, while arrangements were taking place to recruit staff to undertake this role.

The centre had policies and procedures in place for managing complaints in the centre. The procedure for making complaints was user-friendly and was on display in the front hallway. There was also a guide explaining how to make a complaint available to residents and their representatives near the front entrance. The policy named a nominated person to manage complaints and a nominated person to oversee the management of complaints.

The inspector spoke to a number of residents and relatives and asked if they knew what the procedure was if they wished to make a complaint. All were aware of who they could speak to if they wished to make a complaint and all made complimentary comments towards the staff and the person in charge stating that they felt staff and management would act upon any complaints or concerns they raised immediately.

**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):**

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

**Findings:**

There were appropriate staff numbers and skill mix to meet the needs of residents on the day of the inspection. The inspector also reviewed the actual and planned rota and found that there was enough staff on duty seven days per week to meet the specific needs of residents outlined in the statement of purpose while taking into account the size and layout of the centre. Two registered nurses (including the person in charge) and four care assistants were on duty at the commencement of the inspection. The general manager was also working at the centre. Additional staff on duty included the catering-chef and two kitchen assistants, housekeeper, and receptionist. There was always one registered nurse rostered on duty every day. The number and skill mix of

staff on duty is subject to constant review by the person in charge.

Staff confirmed they had access education and training to meet the needs of residents as outlined the statement of purpose. Staff had received a broad range of training suitable to meet the assessed needs of residents. For example, end-of-life care, wound care management, infection control, journey of life, dysphagia, and risk management training. A falls management training day had taken place with a second date identified for additional staff to attend further to the last inspection and action plan response. However, as outlined in outcome 7 some staff did not have up-to-date mandatory safeguarding training.

The training plan for 2017 was discussed with the person in charge and the inspector and planning was found to be satisfactory.

Training includes medication management, infection prevention and control, and falls prevention and management.

The provider gave the inspector a detailed overview of how staff will be supervised appropriately and how any new staff are recruited, selected and vetted in accordance with best recruitment practice. Garda Clearance that is required in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was received. A sample of staff files were checked and all schedule 2 information was found to be in place in line with legislative requirements.

At the time of inspection there were no volunteers in place but the person in charge was aware of the vetting procedures that need to be in place should volunteers become part of the team.

There is a recruitment policy in place and the inspector was satisfied that staff recruitment was in line with the regulations. All relevant members of staff have an up-to-date registration with the relevant professional body.

There is a good system of formal supervision and appraisal is in place. The person in charge said that she has a system of supervisory meetings and a process of staff appraisal is in place, where staff would also have an opportunity to request additional training relevant to their role.

Systems were in place to provide relief cover for planned and unplanned leave. The person in charge said that staff cover will be provided from within the existing staff compliment to ensure consistency in providing care. A senior staff nurse had recently retired and a replacement had been recruited as a deputy. However, the administration manager confirmed recruitment was ongoing and further staff nurse post would be recruited into.

A daily communication system was established to ensure timely exchange of information between shifts which included updates on the residents' condition.

The inspector observed all staff interacting with the residents and person in charge in a professional and respectful manner.

**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:***

Leone Ewings  
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>	Cedar House Nursing Home
<b>Centre ID:</b>	OSV-0000023
<b>Date of inspection:</b>	08/02/2017
<b>Date of response:</b>	20/03/2017

#### 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 01: Statement of Purpose

**Theme:**

Governance, Leadership and Management

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

The statement of purpose required updating with details of the organizational structure.

**1. Action Required:**

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

<sup>1</sup> 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:**

Organisational chart submitted. Statement of Purpose reviewed.

**Proposed Timescale:** 20/03/2017

### **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:**

Bedrail risk assessment documentation was not fully in line with national policy, where alternatives trialled were not fully evidenced in the records reviewed.

**2. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

Alternatives to bedrails will be documented in resident's care plans.

**Proposed Timescale:** 20/04/2017

### **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:**

Thirty staff did not have evidence of up-to-date safeguarding training.

**3. Action Required:**

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Safeguarding training will be completed for all staff.

**Proposed Timescale:** 30/06/2017

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

The safeguarding policy had not been fully implemented and required updating in line with best practice, in terms of the frequency of training.

**4. Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

Safeguarding policy reviewed.

**Proposed Timescale:** 20/03/2017

**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:**

Equipment including basins and bedpans were inappropriately stacked and stored in an open cupboard where a wall-mounted drying rack was not in place.

**5. Action Required:**

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

Wall mounted drying rack will be fitted.

**Proposed Timescale:** 30/04/2017