Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Cairn Hill Nursing Home Bray
Name of provider:	McMahon Healthcare Limited
Address of centre:	Herbert Road, Bray, Wicklow
Type of inspection:	Unannounced
Date of inspection:	26 March 2018
Centre ID:	OSV-0000755
Fieldwork ID:	MON-0021334

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The centre is based in Bray and has good access to local amenities including bus routes. The premises are purpose built and provided over three floors offering 93 places for men and women over the age of 18. Bedroom accommodation is predominantly single en-suite rooms, with five additional double en-suite.The centre provides for minimal support up to total nursing care, and can offer convalescence care, palliative care, respite and long term care.

The following information outlines some additional data on this centre.

Current registration end date:	28/08/2019
Number of residents on the date of inspection:	93

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
26 March 2018	09:30hrs to 17:00hrs	Helen Lindsey	Lead
26 March 2018	09:30hrs to 17:00hrs	Sarah Carter	Support

Views of people who use the service

Residents' were very positive about the service being provided in the centre. All who spoke with inspectors said the staff were very kind and provided them with the support they needed and respected their privacy and dignity at all times. They were positive about the premises and how they had been able to personalise their rooms, and also about the location which meant they could easily access the local amenities.

Inspectors spoke with residents who enjoyed spending time in the communal areas and joining in the wide range of activities provided. They described the their interests prior to moving in to the centre and how they are able to continue them in the centre. Many also commented that the range of opportunities to practice their religion was important to them. Other residents preferred to spend their time in the privacy of their own room, and confirmed this was fully respected by the staff, but that they still had the opportunity to engage in any activities or celebrations in the centre.

Residents' were also positive about the quality of the food, and confirmed they were always offered a choice. They confirmed snacks and drinks were made available when they wanted them, and also offered to their visitors, which they said made it feel homely.

Capacity and capability

This was a well organised and managed service. There were effective systems in place to support the provider and person in charge to have good oversight of the service being provided. One area that required improvement related to staff recruitment.

The management team was made up of people with leads in different areas of the service. They met regularly and discussed the performance of the centre in each of those areas, for example health and social care, facilities, and human resources. They reviewed key information gathered using a range of approaches including audits, document reviews, and clinical indicators. They also reviewed any feedback from residents and their families, including any complaints made. One area for improvement was that while there were thorough recruitment practices in place, a sample of staff records found that two staff had commenced employment prior to the Garda vetting being received. One remained outstanding at the time of the inspection.

Inspectors found each grade of staff was aware of their role and the duties they needed to carry out. To ensure good quality health and social care was being provided senior staff members were then allocated to oversee care and support being provided. They would check care plans were being implemented fully, for example, and spot check that residents were satisfied their needs were being met. This was seen to have a positive outcome for residents who said their privacy and dignity was respected ad their needs met.

Where trends of incidents or improvements were identified there was an assessment of the information and a plan was put in place to drive improvements. Areas they had completed this for included falls and care records, and improvements were noted in both areas. Where it was identified improvements were required the action required was recorded and reviewed to ensure the agreed action was taken. For example residents had fed back in a survey they would like the opportunity to get out of the centre more, and roles had been recruited in the centre to provide this.

Staffing levels were kept under review by the management team. The staff worked in three teams, each allocated to a floor. This supported them to get to know the residents needs well and supported person centred care. Families who spoke with inspectors through the inspection were very positive about the personal approach of staff and their skill in responding to and managing any changes in health and social care needs. All staff spoke with were clear of the policies and procedures in the centre including what to do if there was a fire or there was an allegation of abuse made to them. Other courses available included dementia care, managing responsive behaviour and end of life care. Staff were seen putting their skills in to practice and communicating effectively with residents and where appropriate their families.There was a full complement of staff at the time of the inspection.

Regulation 15: Staffing

The skill mix of staff available in the centre met the needs of residents. The numbers of location of staff were appropriate for the layout of the building. There were nursing staff available at all times, and they were supported by healthcare assistants to met residents health and social care needs.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a range of training courses to ensure they had a good understanding of the needs of older people. Course provided included those for fire safety and safeguarding to ensure staff were familiar with the policies and procedures in the centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in the centre, and the governance and management arrangements ensured issues were known to the management team. The centre was resourced appropriately to ensure all areas of the service were providing a quality service to residents.

Judgment: Compliant

Regulation 24: Contract for the provision of services

There was a clear contract for the service being offered, and they were signed when the residents arrived at the centre for long term of respite care. The contract clearly set out the fees to be charged and the room the resident would occupy, including if the room was a single or shared room.

Judgment: Compliant

Regulation 30: Volunteers

Volunteers had a clear description of their role and a Garda vetting disclosure prior to starting to volunteer in the centre. Supervision was provided by a nominated person in the area they supported.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications were made of any incidents or accidents in the centre within three days.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints policy in the centre, and an easy-to-read version was on display through the centre. Residents confirmed they knew who to speak to if they wanted to raise any concerns.

Judgment: Compliant

Regulation 21: Records

At the time of the inspection one staff member was in employment without a current Garda vetting disclosure in place.

Judgment: Not compliant

Quality and safety

Residents' were receiving a good standard of care and support. They were involved in reviewing their care and health and social care needs on a regular basis and there was access to healthcare professionals being arranged when needed. There were effective systems in place to ensure safe practice in relation to safeguarding residents from harm, medication management and fire safety.

Each resident had care plans in place that reflected their identified needs and were

based on a thorough assessment completed on admission. A range of nursing assessments were used to regularly review and evaluate residents' needs and to identify if there were any changes. Where there were changes records showed that these were addressed quickly. All care plans were reviewed every four months or more frequently if required. Residents' were involved in the care planning process and records reflected individual preferences. This supported person centred care to be delivered in the centre and good health and social care outcomes were seen for residents, for example low levels of incidents such as falls resulting in injuries. Residents advised inspectors that they were being supported to maintain their independence where possible and their dignity was maintained by a staff team who were respectful at all times.

Where residents had responsive behaviour staff were seen to be aware of the things that may trigger their anxiety or frustration and were working to reduce the risk of them occurring. Where residents did become agitated staff were knowledgeable about what to do to manage the situation and ensure the residents were safe. Where incidents had occurred they were reviewed and care plans were amended where necessary. There were links with the psychiatry team and other relevant teams to support the resident.

Residents in the centre had a wide range of healthcare needs and staff were seen to have the skills to provide the appropriate care and support. Where healthcare professionals had made recommendations for treatments or approaches there were systems in place to ensure they were put in to practice, for example if residents had been prescribed modified diets the correct consistency meals were prepared and given to residents with a series of checks to ensure each resident received the right meal.

There was an effective structure in place to ensure that key policies and procedures were in place and followed in practice. This included in the areas of fire safety, medication management, safeguarding and restrictive practice. The management team or lead staff reviewed practice in the centre against national guidelines and provided advice and training to staff. Inspectors reviewed copies of the checks and audits that were carried out to ensure safe practice in the centre, and also spoke with staff who they found to be knowledgeable about their roles and any actions they were required to take. Residents and relatives informed inspectors they felt safe in the centre.

Through the inspection residents were seen to be involved in a range of activities, some in groups and some independently. There were activity co-ordinators allocated to each floor that ran a range of activities including games, religious studies, newspaper and book readings, arts, singing, music and discussion groups. Recent feedback from resident questionnaires had fed in to some changes to the activity programme and also more focus was being given to trips out of the centre either for walks or to visit local amenities. Residents' confirmed they were supported to make choices each day in relation to how they spent their time in the centre, and also to engage in things that were meaningful to them.

Regulation 25: Temporary absence or discharge of residents

Arrangements were in place to receive relevant documentation ahead of resident admissions to ensure the service was ready to meet their needs. When residents were leaving for appointments summaries of the care being delivered was made available including any prescribed medication.

Judgment: Compliant

Regulation 28: Fire precautions

Arrangements were in place to manage the risk of fire in the centre. Fire equipment was regularly checked and serviced, staff received annual training and regular drills were carried out to test all staff knew what to do in the event of a fire. Fire exits were clearly signed and free from obstructions.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Arrangements were in place for the safe receipt, storage, administration and disposal of medication, including controlled drugs. Audits were carried out to ensure practice was in line with national guidelines and nurses carried out medication administration training to keep their skills up to date.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents' needs were assessed prior to a place being offered to ensure their needs

could be met. On admission a full review was carried out and care plans were put in place to address all health and social care needs identified. Care plans were seen to give clear instructions to staff on how resident needs were to be met and also included likes, dislikes and preferences. Practice was seen to follow the directions set out in the plans.

Judgment: Compliant

Regulation 6: Health care

There was access to a range of healthcare professionals in the centre to meet residents' needs. Where care approaches had been recommended records confirmed they had been put in to practice.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Assessments were carried out to identify the underlying causes for residents with responsive behaviour. Care plans were then developed and staff were seen to be putting them in to practice.

Judgment: Compliant

Regulation 8: Protection

Staff were knowledgeable of what to do if they observed or had abuse reported to them, and knew the detail of the policies in the centre to safeguard residents.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had the right to make choices and decisions about their lives. There was access to a range of religious services and meetings, and also a wide range of activities to reflect residents interests.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Not compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cairn Hill Nursing Home Bray OSV-0000755

Inspection ID: MON-0021334

Date of inspection: 26/03/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

Following the inspection feedback, the employee without a current garda vetting disclosure was removed from the roster pending the outcome of the vetting process. The garda vetting disclosure was obtained on 05/04/18 enabling the subject staff member to be added to future rosters. A Schedule 2 records audit was undertaken of all staff files post inspection; the audit confirmed that all existing staff records comply with the requirements of Regulation 21(1).

To ensure ongoing compliance in relation to Regulation 21 Schedule 2 Records, the following compliance plan has been implemented:

- The Support Services Manager is responsible for ensuring that all Schedule 2 records are in place before a staff member commences employment.
- The Support Services Manager is responsible for creating staff rosters therefore no staff member will be rostered to work until all Schedule 2 records have been submitted for their file.
- The Support Services Manager will prepare a monthly update for the Management Team Meeting to advise on new staff hires and whether their staff file is complete in advance of commencing employment as per Schedule 2 requirements.

In relation to ongoing compliance with Regulation 21 generally (including Schedule 3 and 4 Records), the Senior Management Team undertake a range of scheduled audits, including monthly documentation audits, to ensure ongoing compliance with Regulation 21. Any identified non-compliances are added to the Quality Improvement Plan list which the Clinical Nurse Managers are responsible for actioning and closing out. Audit findings are presented to the monthly Management Team Meeting and if there are any areas of improvement required from a resourcing or staffing perspective, a plan is agreed and implemented to ensure continuous improvement in the quality of service provided to our Residents.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 21(1)	The registered provider shall 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.	Not Compliant	Red	04 May 2018