Cedar House Nursing Home, OSV-0000023, 21 October 2019

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Cedar House Nursing Home
Name of provider:	Cedar House Nursing Home Company Limited By Guarantee
Address of centre:	35 Mount Anville Park, Goatstown, Dublin 14
Type of inspection:	Announced
Date of inspection:	21 October 2019
Centre ID:	OSV-0000023
Fieldwork ID:	MON-0022696

About the designated centre

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

Cedar House is a single-story, purpose built nursing home under the care of the Society of the Scared Heart. The building is set within the grounds of Mount Anville House and can accommodate 24 residents. Cedar House Nursing Home opened in 1983 to provide long and short-term nursing care for Religious of the Sacred Heart, and now accepts residents from other orders and lay-people. Residents over 65 will be accommodated, and 24 hour nursing care is provided to both male and female residents. There are a variety of scheduled activities on offer and residents privacy and dignity is a high priority.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as 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
21 October 2019	09:00hrs to 17:10hrs	Sarah Carter	Lead

What residents told us and what inspectors observed

A number of questionnaires had been completed by residents and their relatives or visitors prior to the inspection and these were reviewed by the inspector. In addition the inspector spoke with residents, a small number of relatives and visitors to the centre, and observed a lunchtime experience.

Residents were consistently positive in their feedback about the service they received and the staff interactions with them. They also told the inspector they felt there was enough staff who cared for them and attended to their needs quickly.

Residents said the centre was a pleasant and safe place to live, that they liked their rooms and the facilities, especially the library facility, the garden areas and the on-site roman catholic church. Residents said they had enough to do, and felt no obligation to attend planned activities if they did not want to.

Resident said the food was really enjoyable and they liked the choices there were given and were also given any special requests they may make.

Visitors and relatives told the inspector they were happy with the centre, and felt they were consulted appropriately.

The lunch time meal that was observed looked and smelled pleasant and was served in a bright and airy dining room, which overlooked a small sun terrace. There were sufficient staff on duty, and assistance being offered was discrete.

Capacity and capability

The inspection was announced in advance. The inspector found that the service provided effective care and had developed and maintained a culture that protected residents rights and enhanced their well-being.

There was a stable management team in place, who worked together and were knowledgeable of services provided. The management team were responsive to any findings, observations or requests, that indicated parts of the service needed improvement.

There were advantages to this management style evident on inspection:

- The managers had hands-on and up-to-date information about residents.

- The person in charge attended daily handover meetings and used this forum to disseminate any information quickly to staff.
- Managers were well known and available to residents and their families on a day–to-day basis and were consistently present in the centre.

While this management style was effective, there were gaps in the management teams' abilities to measure and monitor the service and identify quality improvement projects.

There was no formal system or schedule of audits place. Some gaps in oversight were identified by the inspector that had not been picked up by the management team. These gaps were identified in some clinical records, and in some information required to monitor fire safety. There was an annual review completed for 2018, and it reflected consultation with residents. It did not identify any quality improvement initiatives.

There was a formal governance structure in the centre, and tasks were appropriately delegated amongst managers. There was a formal management meeting taking place once a month, where key issues were discussed amongst managers in the centre. A formal report was also prepared by the person in charge for the board of management which ensured the provider had oversight of the operations in the centre.

There were sufficient resources in the centre. The management team had employed sufficient staff members and delegated duties appropriately to staff members to provide the services they described in their statement of purpose. The skill mix of staff was deemed sufficient to meet the dependency needs of the residents who lived in the centre.

The inspector was satisfied that the centre was being managed by a suitably qualified and experienced nurse who had authority, was accountable and responsible for the provision of the service. The person in charge is supported in her role by staff nurses, and had worked in the centre for a number of years. The person in charge had maintained her professional development in health care topics relevant to her roles and responsibilities by attending seminars and linking with peers.

There was suite of policies available in the centre which met the requirements of schedule 5. Policies had been reviewed within 3 years as per requirements. These standardised polices had been personalised to the centre for the most part, but not in all cases. Some polices specific to risk and fire management in the centre required improvements to ensure they correctly described the practices in the centre. These policies reflected formal systems of risk management and safety committees which did not take place in the centre.

There was staff training being provided in the centre, however a number of a staff required updated training as per the centres own training policy. There were approximately 50% of staff who were overdue to complete training in fire safety and manual handling techniques. 30% of staff required training in safeguarding and

protecting vulnerable adults. Training dates were scheduled for the month following inspection.

There was a complaints policy in place in the centre but there had been no formal complaints received in the centre and no records to review.

The provider had submitted an application to register the centre and paid the correct fee. Documentation submitted by the provider to assist the chief inspector to register the centre, was largely satisfactory. Some corrections and additional details were required in the centre's statement of purpose. During the centres current cycle of registration, the provider had refurbished a twin bedroom into two single bedrooms. This work was not identified to the chief inspector with an application to vary registration conditions when the changes occurred.

Registration Regulation 4: Application for registration or renewal of registration

The provider had made an application to renew the registration of the centre. This did not identify that changes had been made to the premises; as one twin room a had been divided into two single rooms. The statement of purpose submitted required review on some points, as set out under regulation 3.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The person in charge was an experienced nurse, with sufficient experience and skills to hold the role.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that there was staff on duty and on the planned roster to meet the needs of residents and in accordance with the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training, however training had not taken place within the period of time that the provider had set out for staff to repeat their training. This will be reflected in regulations 8, 26 and 28 below.

Judgment: Compliant

Regulation 21: Records

Staff files contained the requirements of schedule 2 of the regulation. All staff had received Garda vetting disclosures prior to commencing their employment.

Records in relation to residents contained all elements of schedule 3 of the regulation.

Records in relation to schedule 4 of the regulation were also complete and available within the centre.

Judgment: Compliant

Regulation 23: Governance and management

The provider had supplied sufficient resources to ensure care was delivered as described in the statement of purpose.

There was a clear and established governance structure in the centre, and staff and residents were clear on the lines of authority and managers roles and responsibilities. The centres managers met monthly and prepared reports and attended meetings with the centre's board of directors.

The governance systems in the centre reflected that hands-on management style of the governance team, however there were some gaps in oversight identified. The governance team had not identified the incorrect details in some of their policies, in some clinical records and in some aspects of fire safety practices and documentation in the centre. Data was being complied on key clinical areas and discussed at management and Board level.

There was a system for assessing risks, and the person in charge had completed risk assessments on key clinical and operational risks. However some assessments and controls required a review to ensure they reflected the full range of controls required in the centre. The hazards and controls in place to manage the risk of fire did not

reflect the absence of self closers on all fire doors, and the details of specific training in place for staff to evacuate the largest fire compartment in the centre. In addition 51% of staff had not received up-to-date training in fire safety, and this was not identified as a risk in the centre.

An annual review had been completed in 2018 and did not identify any quality improvement measures for 2019. There was evidence that resident consultation formed part of the review.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required some additional information to correctly and fully describe the services and facilities available in the centre as it did not correctly describe bedrooms, if day care was offered, and did not include the centres organisational structure

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy in the centre that could guide practices in the area. There was a person appointed to receive complaints and another to oversee the complaints persons work. As no complaints had been received by the centre, there were no records to review. Residents spoken with were clear on the day who they would complain to if they wished to raise any issue.

Judgment: Compliant

Regulation 4: Written policies and procedures

A full suite of schedule 5 policies were available for the inspector to review. All had been reviewed within recent months, and within the last 3 years. Some policies required further updating to ensure that they were fully personalised to the service, and this will be reflected in the individual regulations 26 and 28 below.

Judgment: Compliant

Quality and safety

Care was provided in the centre that met resident's needs and prioritised their well-being.

A wide variety of care plans were reviewed. Care plans had been reviewed, and a combination of residents' requirements and evidence based assessment results informed the plans reviewed. Several general practitioners (GPs) attended the centre, and many residents told the inspector they had maintained their own general practitioners (GP) s on admission. There was evidence of interventions from a dietician professional; however the records of other allied health professionals were not available. Some gaps in monthly care observations were also noted.

Restrictive practices were very low in the centre and a policy that reflected national guidelines was in place. However not all restrictive practices were being viewed and recorded as such.

The provider had protected residents from risks of abuse by provided sufficient resourcing, a hands-on management style, and the provision of a clear policy to guide staff working with vulnerable adults. Staff training was on-going in the centre, and at the time of inspection not all staff had met the requirements and required training in all mandatory areas. All staff had received Garda vetting disclosures prior to commencing their employment and the provider was not acting as a pension agent for any residents.

Residents' recreational and spiritual needs were well met in the centre. There was daily roman catholic mass available in the centre, and a varied activity programme resourced mainly by external therapists and contractors. Residents spoken with liked the activities on offer. Residents had access to wi-fi, computers, telephones, and all other media.

The centre - a single storey premises; was maintained to good standard. It was clean, warm and pleasantly decorated. There were pleasant outdoor gardens with level pathways, and a secure internal courtyard with paving, some of which was uneven. Residents ability to undertake activities in private in their bedrooms that were overlooked by the courtyard or an external walk way was limited, as there was a clear view into the bedrooms from outside. Residents had sufficient space in their rooms for their belongings. Some residents' bedrooms had en-suite facilities and those that did not had access to near-by accessible bathrooms. There was several different seating areas available throughout the centre.

There was a risk management policy in place in the centre. It reflected the information required in the regulation but also listed some committees that were not in operation. Risk assessments were completed by the person in charge.

The centres fire and evacuation plan was clearly advertised throughout the centre, and advised staff to close all doors, but it was unclear if the drills and training

practices in the centre reflected this additional requirement. There was insufficient information available on the day that drills being practices could evacuate the centres largest compartment in an appropriate time frame. Fire equipment was being serviced, however records relating to the servicing of emergency lighting were not available in the centre, and were sent in to the inspector following the inspection. Daily checks on the means of escapes were competed most, but not every day.

Regulation 12: Personal possessions

Residents retained control over and access to their own clothing and finances, and had sufficient personal storage for their belongings.

Judgment: Compliant

Regulation 17: Premises

The premises was clean, well maintained and warm. The external grounds were accessible and pleasantly planted. The bedrooms varied in size, and some had en-suite facilities. There was sufficient bathrooms to accommodate all residents. There was good amounts of seating around the centre, and several smaller communal spaces and rooms for residents to meet their visitors outside of their bedroom.

Judgment: Compliant

Regulation 26: Risk management

A policy to guide staff on risk management was in place, and had been reviewed recently. It referenced the specified risk in the regulations and listed the specific policies that dealt with those risks. However the policy did not accurately reflect practice, as it described a committee structure not currently in place in the centre. A safety statement had been prepared, and again described a committee structure not in place in the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider is required to ensure all fire doors have self closing mechanisms. As discussed above, risk assessment had not been completed to reflect this risk.

Fire management and prevention equipment was being serviced and documentation to prove the centre emergency lighting had been serviced was submitted after the inspection. The schedule of servicing and checks required closer oversight to ensure it was being completed as per the centres own policy - for example the daily checks on the means of escape were not completed daily.

Fire training had been provided but 51% of staff had not completed it.

Drills were being practiced in the centre, but records did not provide sufficient assurance that fire doors were being closed, or the time it was expected to evacuate a compartment in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A variety of care plans reflecting residents who had falls, pressure care concerns, used bed-rails and had nutritional needs were reviewed.

All had been reviewed at intervals not exceeding 4 months, through a process of consultation and repeat assessment.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a general practicioner (GP) and other specialists.

Documentation to evidence that residents had received specialist assessment from allied health professionals was inconsistently recorded in the charts reviewed.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Staff were knowledgeable and were following care plans that reflected their practice in the centre. The policy in place in the centre followed national guidelines.

Judgment: Compliant

Regulation 8: Protection

There was a policy in place to guide staff to work vulnerable residents. Just under 30% of staff required this mandatory training.

There had been no recent safeguarding investigations, as no allegations received by the person in charge.

The provider was not acting as a pension agent for any resident, and was ensuring staff had received Garda vetting prior to commencing their work in the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Resident rights to privacy and dignity were upheld in practice by staff practices and a clear policy.

Not all aspects of the policy were being addressed and bedrooms that were overlooked by other rooms or communal spaces did not have sufficient measures in place to protect the privacy of residents inside.

Residents had access to all media, the Internet and their own telephones in the centre. There was an advocacy service if residents required this type of support.

There was an organised activity programme running in the centre, over 7 days a week. A range of different activities were on offer to meet residents needs. There was a daily roman catholic mass available in the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cedar House Nursing Home OSV-0000023

Inspection ID: MON-0022696

Date of inspection: 21/10/2019

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**
Registration Regulation 4: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration: Statement of purpose reviewed and submitted.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All staff will have fire training provided. Self closers will be installed to all resident bedroom doors, which do not currently have closers. Evacuation of the largest compartment will be practiced. Clinical review meetings will take place every other month, in which policie will be reviewed.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of	

purpose: Statement of purpose reviewed and submitted.

Regulation 26: Risk management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management: A clinical review meeting will be set up for clinical staff and clinical risks will be discussed and actioned as necessary. Any risks and actions necessary will be discussed at the monthly management meetings. This will be reflected in the appropriate policies.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Daily means of escape will be documented accurately in the fire log. Records of fire drills will reflect evacuation procedures and times taken; and fire doors being closed.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: Residents' access to allied health professionals and their recommendations will be consistently recorded.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: All staff will complete safeguarding training.	

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: A privacy film will be applied to bedrooms overlooked by other rooms or communal spaces as necessary.	

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
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Substantially Compliant	Yellow	05/12/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Yellow	29/02/2020
Regulation 26(1)(d)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	05/12/2019

	policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	29/02/2020
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	05/12/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	29/02/2020
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency	Not Compliant	Orange	29/02/2020

	procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	05/12/2019
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	05/12/2019
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to	Not Compliant	Yellow	20/01/2020

	abuse.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/12/2019