Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Hollybrook Lodge
Name of provider:	St James's Hospital
Address of centre:	St Michael's Estate, Bulfin Road, Inchicore, Dublin 8
Type of inspection:	Unannounced
Date of inspection:	21 June 2019
Centre ID:	OSV-0005053
Fieldwork ID:	MON-0024654

About the designated centre

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

Hollybrook Lodge provides residential care to 50 residents. All residents and patients cared for in Hollybrook Lodge have access to specialist medical and nursing care, a wide range of support therapies including Physiotherapy, Clinical Nutrition, Medical Social Work, Speech & Language therapy and specialist aged-care services & treatments including Old Age Psychiatry, Bone Health, and Memory Clinic.
Hollybrook is a secure, bright, purpose built two storey structure with stairs and a lift. There are two units, Robinson Unit on the ground floor, and the McAleese unit on the first floor. There is an enclosed garden for resident's use adjacent to and behind the building, a family room located on the first floor and a designated smoking area for residents located outside the building. Each unit provides accommodation for 25 residents.
The philosophy of the Centre is to provide holistic person-centred care that promotes and safeguards the well-being and rights of each individual. The ethos of the Centre is to create and maintain a suitable space for each resident ensuring individual privacy with space for their personal belongings and possessions in addition to facilitating recreational activities.
The Hollybrook Lodge Residential Care Centre is managed by the Medicine for the Elderly Directorate of St James Hospital. The scope of the directorate services comprises acute in-patient, rehabilitation, out-patient, day care, transitional care, residential care and community outreach.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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 June 2019	09:30hrs to 18:15hrs	Sarah Carter	Lead
21 June 2019	09:30hrs to 18:15hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

Residents told inspectors that they were satisfied with the care they received. They said they could see the doctor when they needed to and had accessed specialists when required. They told inspectors that staff were caring and kind.

Residents spoken to who had single rooms reported they liked their room. However depending on the size of the wheelchair they used they found the circulation space a little limited.

Residents in twin room and the four bedded rooms did not speak with the inspectors, and were observed to be either in bed, or sitting by their bedside, at different times during the inspection day.

Residents reported that there was an activity programme Monday to Friday and they enjoyed what they attended, however the majority of residents spoken with felt they would like more activities.

The location of the centre, which is close to a museum, a café, and its pleasant garden were mentioned by residents as something they liked. However residents did say that sometimes they would like to go out but they needed help to go and couldn't go alone.

Residents reported the food available in the centre was good, saying that while it wasn't like home, it was satisfying and they could have snacks outside of mealtimes if they required it. Inspectors observed some residents who were not able to communicate sitting for long period in the dining areas on the units with a tray and place setting on front of them, up to 50 minutes before mealtime commenced.

Relatives who spoke with inspectors said they were satisfied with the care the resident was receiving and that staff always took the time to communicate with them about how the resident was doing. They reported they felt their relative was safe in the centre.

Capacity and capability

The centre has its own local management team who are part of a wider management group in St James Hospital. The service provided was ensuring residents health care needs were well met. However the resources provided to meet residents' day to day activity and social needs, and to provide and maintain a safe

environment were insufficient.

The centre had a statement of purpose available, and it contained the required information. However it was required to be updated to include details on person in charge and the arrangements to deputise were correct.

The office of the chief inspector had been notified that the person in charge had left in April this year, arrangements had been made that an assistant director of nursing in St James Hospital would replace the person in charge until a permanent appointment was made. However a notification of an appointed person in charge was not received during this time. Inspectors were informed on the day that a person in charge was in process of being formally appointed, and this notification was to be sent in imminently.

The governance in the centre was dictated by the governance structure in St. James Hospital. The statement of purpose defines the centres philosophy as " to create and maintain a suitable space for each resident ensuring individual privacy with space for their personal belongings and possessions in addition to facilitating recreational activities" and to provide care in a "home from home environment". While inspectors were satisfied that sufficient resources were in place to meet care needs through the nursing and health care assistant roster on both units (this will be described further below), it was not clear that sufficient resources were in place to meet residents' recreational needs. One member of staff was appointed to the role of activity co-ordinator, and planned, recorded and organised residents activity groups. However inspectors were told that up to 90% of the residents on site had dementia or a similar cognitive impairment, and many were observed throughout the day not engaged in any meaningful activity. There were arrangements in place to manage resident's recreational needs at weekend, however this relied on unit staff to follow plans drawn up by the activity co-ordinator. Records of weekend engagements were not seen. There was also evidence of insufficient resources being provided to maintain the building (the deficits in the premises will be detailed in the next section of the report).

As discussed above the governance structure was part of the wider St James Hospital structure, and senior managers from the hospital and the designated centre met regularly at different committees and meetings. While this provided the centre with a close relationship with a nearby hospital, some aspects of the wider structure did not meet the requirements of the designated centres regulations, for example:

- Some policies required by schedule 5 of the regulations, were out of date, having not been reviewed within the three yearly requirement. This was due to the fact that policies were reviewed centrally and in line with the main hospitals requirements.
- Records relating to personnel and Garda vetting were not maintained on site in the designated centre. When requested, personnel records arrived promptly from the main hospital, however it is a requirement of the regulation that records are kept in the designated centre.
- Gaps were identified in staff training.
- Delays in addressing maintenance issues, which were reported to a central

facility in St. James Hospital.

There were systems in place to monitor the effectiveness of the service, and audits were completed regularly. Adverse incidents were reviewed both at meetings within the centre and though reports given to committees in the wider hospital structure.

Suitable and sufficient staffing and skill-mix were found to be in place to deliver a good standard of care on the units with the exception of activity provision. Inspectors found that there was adequate supervision and direction for staff by the nurse managers. Actual and planned rosters were in place in each unit. The staff rota was checked and found to be maintained with all staff that worked in the centre identified. There was a separate roster in place to facilitate one to one care for the residents that needed additional supervision. There were systems were in place to provide relief cover for planned and unplanned leave.

Training records were reviewed and evidenced that all staff had been provided with opportunities to attend training. Nursing and care staff were supervised by clinical nurse managers on each unit. As a result staff who spoke with inspectors reported that they felt supported in their role and were clear about the standards that were expected of them in their work

Objective setting was in place for all nursing staff and were reviewed every three months, these objectives were found to be task based, and were set by staff themselves and signed off by their manager. Performance plans were used to address issues of staff performance.

When the staff training matrix was reviewed, gaps were identified. All staff were up-to-date with manual handling training, however 29 staff had not attended mandatory yearly training for fire evacuation. A very small number of staff were due to attend safeguarding training and hand hygiene training, and these dates were imminent.

There was a facility to have volunteers in the centre and Garda vetting disclosures were available, however their role and responsibilities were not set out and available for the inspectors to review.

Complaints processes were well managed in the centre and complaints raised were mostly resolved at local level. This was an area where the centre benefited from being part of the wider hospital, and an external member of staff was appointed to oversee the complaints officers work and there was also a larger complaints department available if the complaint was escalated. Complaints received since the last inspection were followed up, and found to be promptly resolved with the satisfaction of the complainant listed. Residents knew who they could raise a complaint to and the process was advertised within the centre.

Registration Regulation 6: Changes to information supplied for registration purposes

The registered provider did not notify the chief inspector of the identity of the person in charge and did not supply their information as required in schedule 2 of the regulations.This did not occur within 10 days of the person in charge ceasing her role, or within 10 days of her replacement being appointed.

Judgment: Not compliant

Regulation 15: Staffing

There were sufficient nurses and care assistants on duty to meet the needs of residents. There was a registered nurse on duty at all times. Other insufficiency's in resources were judged in regulation 23.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training in the main hospital and on-site. Staff were supervised in their roles and were aware of the Act and the regulations. A very small number of staff were due to complete their mandatory training on a date immediately after the inspection. The requirement for up-to-date fire training is judged in regulation 28.

Judgment: Substantially compliant

Regulation 21: Records

Staff records were requested and received promptly, and contained all aspects of schedule 2 documents , as required. However it is a requirement to keep records in the designated centre, and staff records were maintained in a secure office away from the designated centre.

Judgment: Not compliant

Regulation 23: Governance and management

A review was required to ensure that sufficient resources were available to meet residents recreational needs and to provide a home from home environment, both of

which they described in their statement of purpose.

The governance structures were clear in the centre, and it was clearly defined how this structure fitted in the larger governance structure of St James Hospital. Managers were clear what lines of authority they must follow.

Systems were in place to monitor and ensure the safety of care provided, however gaps in relation to completing maintenance requests and managing training needs existed.

The annual review was not reviewed on this inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to reflect changes in the person in charge (PIC) and the personnel who would deputise for the PIC if she was absent.

Judgment: Substantially compliant

Regulation 30: Volunteers

The person in charge had the services of volunteer's on site; and they had supervision and support in their roles. Garda vetting disclosures had been received however their role and responsibilities were not set out in writing.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy in place, and practices observed on the day mirrored this policy. The process was on display in the centre, and efforts were made to resolve complaints quickly and at a local level. A record of complaints was maintained on each unit, and apron was appointed to oversee the complaints process.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule file policies were available in the centre. A small number of policies had not been reviewed at the three yearly intervals, and were out of date.

Judgment: Not compliant

Quality and safety

A good standard of care was provided. The use of bed-rails had decreased since the last inspection. Less restrictive measures, and alternatives to bedrails, had increased. However some evidence of institutional practices were observed and efforts were required to promote person-centred practices.

Samples of clinical documentation including nursing and medical records were reviewed. The pre-admission assessments were comprehensive and looked at both the health and social needs of the potential resident immediately before the admission and ensured that the on-going needs for care could be met.

Residents had care passports in place and these were updated regularly and used when a resident care was transferred to any other care setting.

Residents had access to medical care, out-of-hours doctor services and a full range of other services available on referral, including occupational therapy, speech and language therapy, dietitians, chiropody, dental services and optical services. Each resident was discussed by the multidisciplinary team every two months and a falls bundle referral system was in place following any resident sustaining a fall and care plans were up-dated accordingly.

Evidence of referral to and review by specialists was available, with early recognition of the signs of clinical deterioration and appropriate management.

Risk assessments and care plans were reviewed every four months or when a residents' needs changed. However, some improvement was needed to ensure that care plans were more person-centred, for example in the care plans to manage residents responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Some these care plans did not outline the triggers or guide staff clearly on the interventions that could help manage the responsive behaviours.

PRN medication (as needed medication) formed part of the therapeutic care to manage behaviour that is challenging, however, guidance was unclear to guide staff

when to use this medication. Examples of this were, PRN medications being given nightly without any reference to the responsive behaviours that triggered its requirement, and PRN medication being given for responsive behaviours despite the outcome of other behavioural interventions being documented as successful.

Promotion of a physical restraint free environment had improved since the last inspection. Through a quality improvement approach, the numbers of bedrails in use had decreased substantially. A small number of bed rails were in use at the time of inspection. Inspectors observed good use of less restrictive measures such as ultra-low beds, crash mats and mattress alarm systems. These less restrictive measures, combined with staff vigilance provided an effective alternative to bedrail use, and improved falls management and resident safety.

Policies relating to the management of challenging behaviours and restraint use were out of date since 2016 but inspectors were told a draft was with the policy review group in the St. James Hospital and was due to be signed off shortly (this is reflected in the judgment on Regulation 4 above).

An example of policies in use based on standard hospital procedures as opposed to best practice in designated centres included the policy on medication which required residents to wear a wrist identification bracelet with a barcode. This practice combined with other observations lead inspectors to give feedback on institutional care practices:

- Residents sitting out at their bedsides for significant periods during the day of inspection.
- Residents remaining in bed until noon, with their bedroom doors open.
- Residents being placed in the dining area up to 50 minutes before meals were served.
- Blood Pressure monitors were observed in the rest and seating area at the end of the corridor.
- Staff routinely referred to residents as patients, and this terminology was seen in documentation in the centre.

The premises consisted of two floors; Robinson Unit on the ground floor, and McAleese Unit on the 1st floor. 25 residents can live in each unit. Both units had the same layout; a centralised corridor with 17 single rooms, 1 twin room and 1 four bedded room close to the exit and the nurses office. Each unit had a large room which combined both a dining area and a living room area. Two spacious lifts were available to travel between floors. On the ground floor there was a large activity room, with direct access to the garden area and a pathway, and a separate large room used for both religious and recreational activities.

There was a visitors space on the first floor which contained a comfortable sofa and a small kitchenette. However this room remained locked, and visitors spoken with were not aware of its availability. The management team understood how the provision of a private space for visits could enhance a resident's life in the centre the and committed to promoting its availability to visitors. Visits were not restricted in any way, and were seen to take place in residents' bedrooms, the dining area and

the outdoor garden.

The storage of equipment had improved since the last inspection; and equipment was observed to be stored appropriately and not in bathrooms or on corridors. In the last inspection which took place in January 2018, deficits in premises maintenance were highlighted and were the subject of an action plan by the provider. Additional deficits in maintenance were found on this inspection:

- Wear and tear evident on paintwork throughout communal areas and in bedrooms.
- A hole in the ceiling of the lift lobby of the first floor had not been suitably fixed.
- Odours similar to damp or water ingress in bathrooms and sluice rooms.
- Poor ventilation in internal sluice rooms.
- An accessible bathroom did not have toilet seat and broken tiles were evident at floor level.
- Broken lamp and lampshade in the seating area at the end of the corridor.
- Garden area contained an enclosed metal pipe that crossed the main walkway close to the main exit to the garden which posed a trip hazard.

Inspectors were told that maintenance issues were recorded in log books at unit level, and these were seen. Tasks were ticked off when completed, but most did not list a date of completion, and it was not possible to summarise how long maintenance requests took to be resolved. Inspectors were also told that maintenance issues had the oversight of the operational team in St James Hospital and a contractor had been employed to address issues identified. However due to investment in fire prevention measures, highlighted in the centres last action plan, the budget to address additional issues was limited. The fire prevention measures will be discussed below.

Regular fire drills were taking place, and records showed clear learning points and items for action. Equipment to prevent, detect and respond to fire was serviced routinely. Following the last inspection mechanism to release doors in the event of a fire alarm had been retro-fitted to bedroom doors. However these were deemed unsuccessful by both the management team and staff. Staff were still required to close doors in the event of a fire alarm. Staff spoken with on the day were knowledgeable about the compartmental evacuation procedures in place, but did not report the need to close doors as part of an evacuation. Throughout the inspection, both inspectors noted and observed multiple fire door been wedged open inappropriately. Twenty nine staff were overdue to have their annual fire evacuation training.

Facilities for recreation were provided, however as stated in the earlier section of the report, inspectors were not assured that all residents' had sufficient opportunities to participate in activities in line with their interest and capabilities. The activity staff recorded residents' ability level and their preferences in a handover sheet, however this handover sheet was in use in only one of the two units. Residents were surveyed and had regular meeting to share their views which was chaired by a

member of staff from the main hospital campus. For times when the activity staff members was not available, a resource folder was available to guide unit staff on residents preferences. However records of residents' engagement during these times were not available. Residents privacy could be upheld by privacy screening in shared rooms or closing the doors of the single bedroom, however practices observed on the day indicated that bedroom doors were often open to the corridor. Residents had access to TVs and newspapers, and steps were being taken to create a mobile shop for residents to access some day to day supplies. Residents could access roman catholic religious services on site, and in nearby churches if required and arrangements were in place for members of other faiths.

Residents had access to advocacy services, however this was not fully independent as the advocate was a member of staff of the main hospital.

Regulation 11: Visits

Visitors were not restricted in the centre, and there was sufficient communal space provided for residents to meet their visitors. A private space was available in the centre for visitors however its use was restricted, and visitors were not aware that the facility was there.

Judgment: Compliant

Regulation 17: Premises

The premises did not meet the requirements of schedule 6 of the regulations. It had poor ventilation in internal sluice and bathrooms, showed significant signs of wear and tear, and a trip hazard in the garden had not been addressed which limited resident's use of the pathway.

There were equipment storage rooms on the first floor, handrails on corridors and call bell facilities in resident's bedrooms. There was large kitchen on the ground floor that prepared the residents meals.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had taken adequate precautions to minimise the risk of fire.

A trial of door closure mechanisms installed after the last inspection had not been

successful. This required staff to continue to be vigilant in the event of a fire emergency and close all doors manually, as stated in the centre's displayed evacuation plans. However staff did not tell inspectors this, and several doors were wedged open throughout the day of inspection.

29 staff had not received annual fire training.

Drills were practiced regularly, and where issues were identified, a person was appointed to take action and resolve the issue

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were reviewed regularly by a multi-disciplinary team. Where a specialist had made recommendations, these were reflected in the care plan. Care plans were found to use language in line with acute care, and psychological care plans contained person-centred information.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a general practitioner, and treatments were given to residents that the GP prescribed. Residents could see specialist doctors and allied health professionals when required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Physical restraint practices (for example bedrails) had reduced by a significant amount in the centre, and less restrictive measures were in use. Where residents were prescribed PRN medication to manage their behaviour it was not clear in plans seen that other interventions had been trialled first. The policy for both restrictive practices and managing challenging behaviours were out of date, this is judged in

regulation 4 above.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had made facilitates for recreation available, however a review was required to ensure sufficient opportunities to participate in activities in line with residents capabilities. This is fully judged in regulation 23. Residents were consulted about the running of the centre, via surveys and a regular meeting. Advocacy was available, however it may not be defined as fully independent as it was provided by a member of staff of the wider hospital group. Residents were facilitated to exercise their religious beliefs.

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 6: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Hollybrook Lodge OSV-0005053

Inspection ID: MON-0024654

Date of inspection: 21/06/2019

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 6: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: The NF30A was completed on the 24/6/2019 (NOT-0217946) – The appointed PIC is in place The required documentation was submitted via the HIQA portal (NOR -0217946) on Friday 12/07/2019 Photo identification * 2Personal information form Garda vetting Reference forms Copies of relevant qualification certificates	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Mandatory training - 8 nursing staff and 11 Health Care assistants are now scheduled to complete mandatory training which includes BLS, Management of Actual and Potential Aggression and Manual handling – The 19 staff who had not completed required mandatory courses have been scheduled to complete relevant training on – 25/07/2019 and 26/07/2019 29 staff requiring evacuation training are scheduled to attend on the 11th & 19th of July	

2019.

The Fire Officer has provided extra dates to facilitate the staff -100% of Hollybrook Lodge staff will have the completed fire evacuation training by 31/07/2019

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
St. James's Hospital policy in line with Data Protection legislation requires the hospital to keep staff records safe, secure and only accessible to those who need them in course of their duties.
HR Records are electronic and are accessible on request to the PIC in Hollybrook.
The PIC maintains local records of Hollybrook staff, which includes records of HR compliance.

The inspector has reviewed the provider compliance plan. This actions proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A schedule of works has been agreed with the SJH Facilities Management to upgrade the Residential Unit. This includes:
Replace flooring in the foyer - complete
Programme of painting of communal area – work
commencing 22/07/2019 – Two painters assigned until work is completed – Completion 30/9/2019
General refurbishment / replacement of soft furnishings –Completed 30/9/2019

New maintenance contractor assigned to Hollybrook Lodge - complete
Monthly review of maintenance requirements by MedEl Operations Manager and the Facilities Manager .
Activities available to residents to be reviewed based on need and suitability – 31/08/2019
Incorporate a programme of activities for residents at the weekends and record this

activity – 31/08/2019

The activity coordinator and the PIC to explore other opportunities for therapeutic intervention – visit other units and share experiences – 30/09/2019

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 updated with new PIC registration.
Statement of Purpose includes deputizing arrangements for the PIC
An updated Statement of Purpose disseminated to the Residents

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
A Volunteer Information Pack is provided to new volunteers when they commence which includes a role and responsibility.

A Hollybrook specific Volunteer Policy to be developed

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
MedEl ADON / PIC / to review policies which are out of date and require renewal
Register the updated version of the Communication Policy – completed 26/07/2019
Admission policy currently under review – due for registration 26/07/2019

All updated polocies will be accessible to all staff.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Programme of works identified by Facilities Department / MedEl Operations Manager / PIC – 31/07/2019
New Maintenance Contractor – commencing 21/07/2019–regular written reports will be provided

Inventory of works agreed to address outstanding maintenance issues
Hole in the ceiling in the lobby area – completion 23/07/2019
Review of ventilation in internal sluice rooms –specialist inspection arranged for 6/8/2019
CNMs/PIC to report on outstanding works – complete
Upgrade environment ie painting, flooring and repairs – 30/9/2019
Resolve the "trip hazard" cited in the garden area – removed

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Individual resident's doors to be reviewed – door release mechanisms to be reviewed and replaced as appropriate – full review completed by Fire Officer and
Facilities Management – essential works identified completed by 31/08/2019

Staff evacuation training to address any ambiguity regarding the Fire Evacuation Policy for the Unit – on going as part of mandatory training

Training schedule agreed with Fire Officer and PIC for the 29 staff who require evacuation training – Complete 18/08/2019

The Fire Officer will carry out regular checks to ensure compliance with Regulation 28

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The SJH Challenging Behavioural policy is under review and will be completed by the

31/08/2019. The principles and practices defined in the Hospital's
Policy will be adapted to meet the needs of the residents in Hollybrook Lodge which will be accessible to staff. – 30/09/2019.

The SJH Challenging Restrictive Practices policy is under review and will be completed by the 30/09/2019 – planned completion 31/10/2019

A full review of challenging behaviours care plans will be completed to ensure each care plan is specific to each resident who exhibits challenging behaviours - planned completion 30/09/2019

A chemical restraint registry will be devised and commenced in Hollybrook Lodge to document when PRN medication is given to a resident with responsive behaviours. - planned completion 30/09/2019

A Dementia specific competency is being developed for all staff within Hollybrook Lodge. - planned completion 31/10/2019

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Review of current activity programmes available for residents will be undertaken, The Activity coordinator and the PIC will explore programmes in other centers with a view to developing appropriate activities to meet the needs of the current resident cohort.

The Director of the National Dementia Services Centre has been requested to be an Advocate for the Residents

Proposed timeframes
Review of activity programmes – 31/10/2019
Review of other Centers and possible options for the introduction of more suitable programmes – 30/09/2019
Appointment of independent advocate – 8/08/2019

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 6 (1) (a)	The registered provider shall as soon as practicable give notice in writing to the chief inspector of any intended change in the identity of the person in charge of a designated centre for older people.	Substantially Compliant	Yellow	24/06/2019
Registration Regulation 6 (1) (b)	The registered provider shall as soon as practicable supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of the new person proposed to be in charge of the designated centre.	Not Compliant		24/06/2019
Registration Regulation 6 (2) (b)	Notwithstanding paragraph (1), the registered provider shall in any event supply full and satisfactory information, within	Not Compliant	Yellow	24/06/2019

	10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 2.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/07/2019
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Yellow	30/09/2019
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Yellow	30/09/2019
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	Not Compliant	Yellow	

	the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2019
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.	Substantially Compliant	Yellow	31/10/2019
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 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	Not Compliant	Orange	31/08/2019

	procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/08/2019
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	31/08/2019
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	31/08/2019
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	01/09/2019

Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	26/07/2019
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	31/10/2019
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	31/10/2019
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned	Substantially Compliant	Yellow	31/10/2019

	so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/10/2019
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.	Substantially Compliant	Yellow	31/10/2019