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:	Clarehaven
Name of provider:	Health Service Executive
Address of centre:	St Canices Road, Finglas, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	05 June 2024
Centre ID:	OSV-0007745
Fieldwork ID:	MON-0043674

About the designated centre

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

Clarehaven Community Unit is located in Glasnevin. The centre was refurbished in 2019 and provides residential care for 47 older persons who are of medium, high and maximum dependency. The centre accommodates both male and female residents who are primarily over the age of 65. The centre consists of two single-storey buildings which are divided into two units, Clarehaven and Seanchara. There is a variety of twin and single rooms, and communal areas include living rooms, visitor rooms and a hairdressers. Clarehaven Community Unit aims to provide a quality holistic service to older persons, delivered by skilled professionals that are person centred and recognise the rights and needs of each individual and their family.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

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
Wednesday 5 June 2024	08:00hrs to 16:20hrs	Niamh Moore	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over one day in Clarehaven in Dublin 11. The inspector spent time speaking with residents, observing staff and resident interactions and reviewing documentation. There was a nice calm and homely atmosphere and the overall feedback from residents was generally positive regarding the care provided to them.

The inspector met with the person in charge on arrival to the centre. An opening meeting took place and this was followed by a walk around of the centre. The inspector noted that during this time residents were being supported to have their breakfast in bedrooms or dining rooms, and to get dressed for the day.

Clarehaven Community Unit is divided into two separate single-storey ground floor units, referred to as Clarehaven and Seanchara. The buildings were bright, nicely decorated and spacious. There was residents' art work displayed on corridors and fish tanks in each of the units which created a nice homely environment. The centre was registered for a maximum of 47 residents where the Clarehaven unit had accommodation for 23 residents and the Seanchara unit had accommodation for 24 residents. There were 40 residents present on the day of the inspection. The Seanchara unit was divided into two areas referred to as Oakview and Roseview. Each unit had access to day and dining areas and internal gardens available for residents' use. In addition, there was shared communal space available outside these units such as an activity room, and seating spaces on corridors. There was an end-of-life room available where families could spend time privately with loved ones. The Clarehaven unit had a large room which was utilised as a shared space used for dining and day space. In addition, there was access to a secure garden, an activities room and a smaller sitting room which allowed for a private space to meet with visitors.

Both units comprised single and twin-bedroom accommodation. Residents had access to en-suites or shared toilet, shower and bath facilities. A number of bedrooms were viewed on the day of the inspection and were seen to have been personalised with items such as family photographs, furniture and memorabilia including ornaments, cushions and decorative throws. Overall, residents' reported to be happy with their bedrooms. The inspector observed that each of the twin bedrooms had one television, with one resident commenting that at times when they are watching the television, the person they share with can turn the television off.

At the time of the inspection, residents of the Oakview unit were dining in their bedrooms due to a recent outbreak of COVID-19 and on public health advice. Residents of the other units could dine in the dining rooms or their bedrooms as per their preferences. Menus were displayed on whiteboards in the dining rooms. The inspector observed the lunch-time meal in the Roseview unit and saw that residents were provided with a choice of menu which consisted of beef stroganoff or seatrout,

while dessert options included carrot cake or almond and berry roulade. There was also choice seen to be available at the evening tea-time meal. Assistance was provided by staff in a timely manner for residents who required additional support. The inspector noted that for two residents who did not want to eat their meals or ate very little, staff gently prompted and encouraged them including offering multiple alternative options.

An activities schedule highlighted that this programme was provided seven days a week. Two activity staff were responsible for the activity schedule with support from a volunteer, an art therapist and a clinical nurse specialist in complementary therapy. On the day of the inspection, residents were watching Mass on television, the inspector saw that staff were also engaged in art with residents. Residents' views on the running of the centre were sought through surveys and residents' meetings, that were facilitated by a volunteer and an activity staff member. Feedback from the recent survey was generally positive, any areas for improvement identified had an action plan developed. For example, residents requested more outings to take place and management were seeking access to transport for this.

The inspector observed residents and staff interactions throughout the inspection which on most occasions were seen to be respectful and kind. Care and catering staff appeared to know residents well. However, the inspector observed on one occasion where a resident requested to contact their family that this wish was not acted upon in a timely manner. In addition, one resident told the inspector that while staff were friendly and they provided assistance when they required it, they wished that staff had more time to provide them company and to spend chatting with them.

The next two sections of the report will present findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

Overall, this inspection found that there was a clearly defined management structure in place, with effective management systems ensuring the delivery of quality care to residents. However, some improvements were required to ensure that the documentation in place met the criteria of the regulations, for example for policies and procedures, and volunteers.

This designated centre is operated by the Health Services Executive (HSE). The general manager for older persons' services in Community Healthcare Organisation 9 (CHO9) is the person delegated by the provider with responsibility for senior management oversight of the service. The person in charge was the assistant director of nursing and they reported directly into a director of nursing, who had oversight for four designated centres within CHO9. The person in charge was supported in their role by administration team, two clinical nurse managers grade II,

two clinical nurse managers grade I and a practice development nurse manager. Staff were allocated per unit. Nursing staff were supported by healthcare assistants, activity staff, household and catering staff. The designated centre was also supported by officers, porters, medical officers and allied health professionals.

Evidence was seen that since the last inspection, updates to policies such as for documentation and record-keeping had occurred. The registered provider was in the process of working with an external company to ensure the suite of policies and procedures for the designated centre complied with the requirements of Schedule 5 of the regulations. The inspector was told that in the weeks following the inspection this process was due to be concluded.

There were effective management systems in place through management meetings, committees and regular auditing. This monitored and had oversight of all aspects of the service provided to residents, such as the clinical care, the premises and incidents and accidents.

The registered provider had completed an annual review of the quality and safety of care delivered to residents in the year 2023 in accordance with the National Standards. This review provided an overview of the designated centre and included relevant information such as on how the service met or where required improvements for each standard were outlined within an action plan. Information was provided on advocacy services and complaints received. There was evidence of consultation with residents through a residents' survey and this review was made available to residents.

While evidence was seen that volunteers had a vetting disclosure in accordance with the National Vetting Bureau and a clear role was occurring in practice, improvement was required in relation to ensuring this role was set out in writing. Other gaps identified are discussed under Regulation 30: Volunteers.

There was information about the complaints process displayed in prominent areas of the designated centre. Nominated complaints officers and review officers had received suitable training to deal with complaints. There was a low level of complaints with none received so far this year. The three complaints received in 2023 were outlined within the annual report. The complaints procedure required review to ensure timelines stipulated met regulatory requirements.

Regulation 21: Records

The inspector reviewed four staff files and found that they contained the required information including a full employment history and two written references, including from a person's most recent employer.

Judgment: Compliant

Regulation 22: Insurance

The centre was appropriately insured against injury to residents and to protect their property.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had ensured the designated centre had sufficient resources and good management systems in place to ensure the effective delivery of care.

Judgment: Compliant

Regulation 30: Volunteers

Action was required to ensure that individuals involved in the nursing home on a voluntary basis received supervision and had their roles and responsibilities set out in writing.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints policy detailed that the findings of investigations should be issued in writing within 30 working days, however, it states that if the process is delayed, the complainant should be updated every 20 days on the progress with the complaint resolved within six months at the latest. This was not in line with recently updated regulatory requirements which stipulates that complaints should be investigated and concluded no later than 30 working days after the receipt of the complaint.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

While the registered provider had Schedule 5 policies in place, some of these policies had not been reviewed within the last three years and some required further updates. The inspector was satisfied that there was a plan in place to update the required policies by the end of June 2024.

Judgment: Substantially compliant

Quality and safety

The inspector found that overall residents' medical and healthcare needs were met within this designated centre. Some improvements were required to ensure a safe and good quality service for all residents, particularly in the areas of managing responsive behaviours (how people with dementia or other conditions communicate or express their physical discomfort, or discomfort with their social or physical environment), restrictive practices and upholding all residents' rights to choice.

A selection of nursing records within the Seanchara unit were reviewed on the day of inspection. A pre-assessment was carried out prior to admission to the designated centre and a comprehensive assessment was carried out within 48 hours of admission to the centre. The assessment process involved the use of a variety of validated tools on areas such as the risk of malnutrition and falls. Care plans were generally individualised and many clearly reflected the current health and social needs of the residents.

There was evidence that residents had access to the required allied health professionals when required. There were also links between the centre and a consultant geriatrician based in a local acute hospital and community services such as psychiatry of later life, chiropody and dental services. Residents were facilitated to access the National Screening Programme, in line with their assessed needs.

A restraints register was in place and a policy on the management of restrictive practices was available and accessible to the staff team. The inspector reviewed a sample of records and saw that there was a multidisciplinary approach to restraints. Documentation evidenced that the restraint was discussed with the staff nurse, occupational therapist, medical officer and where relevant the resident's family. There was also evidence of safety checks being completed when bedrails were in use at night-time. While evidence was seen that the registered provider was improving compliance within this area, one restraint care plan was seen to be incomplete and the information of least restrictive measures were not always evident.

Staff had access to training on responsive behaviours. However, improvement was required relating to the creation and delivery of responsive behaviour care plans. This is further discussed under Regulation 7: Managing behaviour that is challenging.

The registered provider had provided opportunities for residents to participate in activities and to provide feedback on the designated centre through surveys and residents' meetings. Residents also had access to advocacy services which were displayed on noticeboards and on leaflets displayed on corridors. However, the inspector found that residents' rights to choice was not always respected.

Overall the premises promoted a good quality of life for residents. The building was clean and well-maintained. The registered provider had support with the external areas through a gardener who was in the process of de-weeding the outdoor areas. Overall storage practices were good, however one store room was not suitable which led to items being stored on the floor, management had requested additional shelving for this area.

Information relating to the designated centre was available through a resident's guide which was seen to be regularly updated. This guide was available on corridors to ensure residents or visitors had access when required. The registered provider was in the process of updating this guide at the time of the inspection to ensure it met all the requirements as set out within the regulations.

Regulation 17: Premises

The inspector found that the premises promoted a safe and comfortable living environment for residents and overall met the criteria of Schedule 6.

Judgment: Compliant

Regulation 20: Information for residents

The residents' information guide had been updated since the last inspection, for example to include the contact details for independent advocacy services. However, on the day of the inspection this guide did not incorporate the terms and conditions relating to residence in the designated centre. The inspector was assured that the registered provider was in the process of reviewing this guide to ensure it met all criteria of the regulations.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Nursing records including individual assessments and care plans were seen to be completed and updated within regulatory timeframes. From the sample reviewed,

overall they contained person-centred information to guide staff on the individual needs of the residents.

Judgment: Compliant

Regulation 6: Health care

The registered provider had ensured that all residents had access to appropriate medical and healthcare, including support onsite Monday to Friday from a medical officer. In addition, the registered provider had access to a physiotherapist, occupational therapist and speech and language therapy, for when such services were required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Improvement was required to ensure that staff had up to date knowledge and skills to respond to and manage responsive behaviours. For example, the inspector observed an occasion where a resident's responsive behaviour was not seen to be followed or effectively supported by staff. In addition, the inspector saw that a behavioural support care plan had not been updated following a behavioural incident to inform staff of changes or additional information on how to best support the resident during a responsive episode. This created a risk that staff would not have relevant knowledge on the management plan for this resident.

Information reviewed in two out of four residents' care records did not provide evidence that the least restrictive measure was trialled prior to the use of a restraint in accordance with the provider's own restraint policy which stated that the alternative measure that has been taken, the length of time trialled, how recently and the outcome of the trial should be recorded prior to the use of a restraint.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights were mostly upheld in the centre, however, residents' rights to choice were not always respected. For example:

- Residents of the twin bedrooms shared a television and therefore did not have full access to that television. For example, in one bedroom, the access

to the television for one resident was reduced if the other resident had their privacy curtain closed. In addition, one resident told the inspector that at times when they are watching the television, the other resident they share a room with can turn the television off.

- The inspector saw a staff member place protective clothing on two residents' during the lunch-time meal, they were not given a choice to use or not to use these and there was limited communication with the resident during this task. This practice was not person-centred and did not promote residents' choice and dignity.

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	
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Substantially 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 Clarehaven OSV-0007745

Inspection ID: MON-0043674

Date of inspection: 05/06/2024

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 30: Volunteers	Substantially Compliant
Outline how you are going to come into compliance with Regulation 30: Volunteers: To fully comply with regulation 30, the following steps will be taken; 1. A Volunteer Agreement document will be developed to reflect clearly the agreed roles and responsibilities of the volunteer and to specify the name and roles of their supervisor for the duration of the agreement. 2. The Unit Volunteer policy will be updated to reflect the use of the agreement and the document template will be added to the Appendix. 3. All staff and current volunteers will be informed of the change in the policy and supported to sign the Volunteer Agreement. This will be completed by 30 September 2024.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The unit is currently working with an external company to ensure the suite of policies and procedures for the designated centre fully comply with the requirements of Schedule 5 of the regulations. The Complaints policy will be updated to reflect the changes to Regulation 34 as outlined in SI628 of 2022. Please note Head of Quality Safety and Service Improvement has escalated divergence between National Policy and Regulation to National Office. The policy will be completed and fully implemented by 30 September 2024.	

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The unit is currently working with an external company to ensure full compliance of policies and procedures as required per Schedule 5 of the regulations.

This work will be completed by 30 September 2024.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
To fully comply with the regulation and to ensure the required information is available to the residents in the information guide;

1. The PIC is updating the Residents Guide to include the terms and conditions of Residency. This will be completed by 31 August 2024.
2. The changes to the guide will be communicated to residents and their families. The updated guide will be presented at the Residents' Committee and displayed on the residents' notice board. A copy of the updated guide will be sent to family members and will be made available in hard copy at the centre. This will be completed by 31 August 2024.

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:
1. The behavioural support care plan referred to in the report has been updated to ensure staff are informed how to best support the resident during a responsive episode.
2. The Restraint Free Intervention Assessment and Multidisciplinary Prescription for Restrictive Intervention Form will be updated to support staff to record the length of time trialled. This will be completed by 31 October 2024.
3. The changes will be discussed at the Restraint Free Working Group.
4. The daily nursing management walk-round will encompass a review of documentation to ensure compliance with policy. Findings, learnings and actions will be discussed and monitored at the internal nursing management meeting with feedback to staff.
5. An audit of care plans will be conducted by the Practice Development Nurse, ADON or

CNMs to ensure appropriate implementation of the policy on the use of restraints. This will be completed by 31 October 2024.
6. A full care plan documentation audit will be completed annually by the Practice Development Nurse. This will be completed by 31 October 2024.
7. Staff will be informed of the new template and refresher training on the Restrictive Practice Policy will be provided to relevant staff by the Practice Development Officer. This will be completed by 31 October 2024.
8. A Managing Responsive Behaviours refresher course is available to all staff. This will be held on 1 July 2024.
9. National Dementia training which includes discussion on the reduction of restrictive practices, human rights and responsive behaviours is provided twice yearly for all staff. All new staff will attend. Current staff are supported to attend as required.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure compliance with the regulation,
1. A review of residents' choice to watch television in their bedrooms will be conducted. This will be recorded as part of their activity care plans and will be reviewed three monthly. This will be completed by 30 September 2024.
2. The PIC will arrange the purchase of a mobile television that will be available to residents who wish to use it. This will be completed by 30 September 2024. As an alternative, a tablet, ipad or radio are available for residents to use as required.
3. National Dementia training which includes human rights and person centered-care is provided twice yearly for all staff. All new staff will attend. Current staff are supported to attend as required.
4. S.T.Age (Socio-Drama tackling ageism, preventing abuse) education programme will be implemented to raise awareness of human rights and to foster empathy among staff and to empower residents. This will be coordinated by the Practice Development Coordinator and Activity Coordinator. It will be completed by 30 September 2024.
5. Nursing Quality Care metrics are completed monthly and include a quality indicator for person-centered care planning to monitor the care provided and identify areas for improvement.
6. All residents care plans are reviewed in full by staff nurses every three months or as required, to ensure they accurately reflect the wishes and care needs of 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 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	31/08/2024
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	30/09/2024
Regulation 30(b)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre receive supervision and support.	Substantially Compliant	Yellow	30/09/2024
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides	Substantially Compliant	Yellow	30/09/2024

	that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.			
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	30/09/2024
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/10/2024
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	31/10/2024

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/09/2024