



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:	Announced
Date of inspection:	21 July 2021
Centre ID:	OSV-0007745
Fieldwork ID:	MON-0033411

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 23 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 is a single storey building which is divided in two units, Blue Haven and Green Haven. 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:	19
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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 21 July 2021	09:00hrs to 19:55hrs	Deirdre O'Hara	Lead
Wednesday 21 July 2021	10:45hrs to 19:55hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This was a good centre where residents were enjoying a good quality of life. From what residents told us and from what inspectors observed, residents were happy with the care they received within the centre and were observed to be content in the company of staff. Inspectors observed many positive interactions between staff and residents and overhead staff discussing topics of personal interest with residents. Overall, inspectors observed a calm and happy atmosphere in the centre throughout the day.

When inspectors arrived at the centre they were guided through infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing-in process, hand hygiene, the wearing of face masks, and checking for signs of COVID-19. Inspectors observed the same process being implemented with visitors throughout the day.

Residents attended mass in the day room each week and one resident was known to lead out on the rosary for residents when they chose. There was also a chaplaincy service available and mass was screened daily for those residents who wished to view it.

The centre was set over one floor while it was seen to be clean and well maintained, however, grab rails were required along both sides of a corridor to assist residents to mobilise if they needed. Improvement was required in fire safety management, storage of equipment in bathrooms and sluice rooms. Improvement was also needed, during out of hours, for residents to be able to their access monies held for safe keeping by the provider

The corridors and communal areas within the registered centre were decorated with pieces of art by the residents. There was ample communal space where residents were able to relax and an enclosed courtyard which was well maintained. Inspectors observed residents in the courtyard sitting enjoying the fine sunny weather in the shade of an umbrella and a large tree. During the inspection morning, flowers had been delivered for a flower arranging activity in the day room and the courtyard. Later that day residents were seen to enjoy their arrangements in the dining and communal areas.

Bedrooms were of an adequate size with sufficient storage space for residents' possessions and a secure locked space available in each room. All bedrooms were either single or twin rooms, with their own en-suite or shared bathroom, other rooms had access to assisted bathrooms. The provider had plans to increase the size of the centre from 23 beds to a 47 bedded centre. This would also provide additional outside spaces for residents and their visitors to enjoy. For the purposes of this report the existing centre will be referred to as Clarehaven and the proposed extension will be called Seanchara. Seanchara is a separate building located on the

same grounds as Clarehaven.

Feedback from residents was sought through a survey done in June of this year. The survey reflected in comments such as a third choice of a meal would be nice, and actions by the provider showed that while other residents were happy with choices, additional choices were arranged for this resident.

The survey showed that nearly all the residents knew how to make a complaint and the complaints procedure was seen to be displayed prominently in the centre. Residents commented that they felt safe and well cared for and that the centre was warm and comfortable.

Residents said they enjoyed getting the newspaper every day and that staff chat away to them as they worked. They remarked that the food was very good and there were choices every day. Drinks and snacks were also available outside of meal times. Dining areas were well laid out and the food was seen to be well presented, where residents who needed assistance, being helped in a supportive and unobtrusive way.

Activities on offer were displayed on a notice board. These included, flower arranging, complimentary and reminiscence therapy, music, arts and crafts, bingo, games and one-to-one activities. Knitting was also available and one of the residents made rugs and hats for a maternity hospital and for cancer research. There was also poetry reading which was led by one of the residents. The hairdresser was available on the inspection day for those residents who wanted hair dressing services.

The centre had a bus available for trips to local areas of interest, which had recommenced recently following a reduction in COVID-19 restrictions. These trips were arranged for small groups to maintain resident and staff safety.

Residents said they could get up or go to bed when they liked and this was seen where some residents preferred to stay in bed until later in the morning and others got up early to have their meals where they chose, such as their bedroom or sitting room. Residents were seen to move freely through the centre and outdoor area.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

The inspectors found that residents received good care and support from staff that was person-centred in nature and facilitated them to enjoy activities of their choice on a daily basis. The layout of the building provided them with plenty of space and access to the outside. Residents could make choices on how they spent their day. However, improvements were required with regard to management monitoring

systems related to records and training.

This was an announced inspection of Clarehaven to review on-going compliance with the regulations and review the registered providers' preparedness to increase bed numbers from 23 to 47, which was outlined in the application to vary conditions of the centres registration. Inspectors viewed the existing registered building called Clarehaven and the proposed new building called Seanchara. These buildings were separated by Clarehavens' courtyard and the entrance to Seanchara.

It was found through the document review and inspection of the proposed new building, that the application to vary conditions to increase bed numbers required improvement to ensure that the centre was suitable to safely receive new admissions. Improvement was required with regard to premises, fire safety, and alignment of the statement of purpose and the floor plans to reflect the actual rooms in the centre. This is further detailed in the relevant regulations below.

The centre is operated by the Health Service Executive, who is the registered provider. There was a clear management structure and the responsibilities and the lines of authority of varied personnel were evident. The structure was understood by staff who knew who they reported to. The person in charge (PIC) was a qualified nurse with the experience and skills necessary for their role. They reported to the director of nursing and senior managers. They were also supported in their role by nurse managers, nurses, health care assistants, allied health professionals, administrative, catering, portering and maintenance staff.

The centre had experienced an outbreak of COVID-19 on 11 January 2021 and was declared over on 24 February 2021. During the outbreak 15 residents and 15 staff contracted the COVID-19 virus and sadly 3 residents died.

There were systems in place to monitor the service, through a range of committees and groups who met regularly to review the quality and safety of services and care given. Clinical and non-clinical data were seen to be discussed at these forums, including care reviews, incidents and a variety of audits which included the responsible persons identified to action any improvements required. However, there were gaps identified during the inspection which were not identified in the centres monitoring of training, with one group of staff requiring safeguarding training. The monitoring of maintenance requests required review to ensure that they were carried out in a timely manner to assure the safety of residents.

An inspector of estates and fire safety attended this inspection to review fire precautions. The buildings were reviewed in the presence of a HSE estates manager. Inspectors noted many good practices in relation to fire precautions; staff spoken with were knowledgeable on the evacuation procedures in place in the event of a fire. Escape routes were kept clear and well maintained.

A third party fire consultant had been retained to review fire precautions in both buildings and produced a fire safety risk assessment report for each. Most risk items identified, were found to have been addressed. Further assurances were required regarding the fire compartment boundaries and the evacuation procedure in place in

the centre.

The provider had ensured that there was sufficient staff available to meet residents' assessed needs. Inspectors examined staff rosters for three weeks and found the planned rosters were updated with subsequent changes made as necessary. This included staffing levels for the planned opening of Seanchara. In Clarehaven there was a minimum of two nurses on duty at all times to meet residents' needs and to ensure a good quality of life in the centre for residents. Inspectors found that care staff were supervised in their work by nursing staff and the nurse managers. All staff received a comprehensive handover of care information at the beginning of each shift.

Staff spoken with reported that they received great support and guidance from the management team, particularly during the COVID-19 outbreak in the centre. Care and services were reviewed by the nursing staff and nurse managers at regular intervals through the day. As a result staff were clear about what was expected of them in their role and showed accountability for the quality of the care and services that they gave. Systems were in place to ensure all new staff who joined the service were appropriately inducted and that all staff working in the centre had completed satisfactory Garda Vetting procedures.

Records and documentation required by Schedule 2, 3 and 4 of the regulations were securely stored. However, records of staff training required by schedule 4 were not kept up-to-date. In addition, all of the records required by Schedule 2: (Documents to be held in respect of staff) were not available for inspection for one member of staff. The provider was required to take urgent action to rectify this situation..

Insurance cover and contracts of care seen contained all the information required by the regulations.

Residents were consulted with and their feedback on the service they received was valued by the provider and the person in charge. There was good evidence that residents' feedback was being used to improve the service, such as more outings into the community or choice of where they ate their meals. The annual review of the quality and safety of the service delivered to residents in 2020 was done in consultation with residents.

Regulation 14: Persons in charge

The person in charge is a registered nurse and works full time in the designated centre. She had experience of working in older persons services and had the required management qualification. She was supported in her clinical management role by a director of nursing and nurse managers.

Judgment: Compliant

Regulation 15: Staffing

There were ample staff resources to meet the assessed clinical needs of residents, having regard to the size and layout of the centre. Inspectors observed that registered nurses were on site during the day and the night to oversee and ensure the clinical needs of the residents were met.

Judgment: Compliant

Regulation 16: Training and staff development

Improvement was required to ensure that all staff in the centre had the required training within the required timescale to ensure that residents were protected from abuse. Training records showed that ten staff did not receive safeguarding training within the required timescale.

Judgment: Substantially compliant

Regulation 21: Records

Inspectors found that not all the records required in Schedules 2 and 4 of the regulations were available in the designated centre on the day of the inspection. These included;

- All documents for staff working in the centre.
- A clear up-to-date record of all staff training. On the day of inspection, inspectors were presented with training records for staff not working in the designated centre.

Judgment: Not compliant

Regulation 23: Governance and management

Systems were not sufficiently robust to monitor gaps in staff training.

The provider had not ensured that the fire evacuation procedures, such as compartments, were adequately identified so that they could be effectively monitored to ensure safe and timely evacuation of the centre in the event of an

emergency.

Maintenance requests were not actively monitored to ensure that the premises met the required safety standards, such as a broken door closing device.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Three contracts of care were viewed and contained all the terms on which residents resided in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

Of the policies seen, they were reviewed within the required time frames and were readily available to staff in the centre.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had the appropriate insurance to cover accidental injury to residents and against loss or damage to their property.

Judgment: Compliant

Quality and safety

Overall, the findings showed that on the day of inspection, the provider was delivering good quality care and support. Some improvements required were identified within fire, personal possessions, premises and infection control.

The centre was found to be homely, well-laid out and appropriately furnished. It had suitable communal areas for the number of residents and their assessed needs. Communal spaces such as dining and lounge areas were spacious and bright.

Inspectors observed the centre to have a calm relaxed energy within these communal spaces on the day of inspection.

Residents' health care and nursing needs were met to a good standard with arrangements in place for assessment and care planning. Care records showed that residents had timely and satisfactory access to allied health and community care professionals. Where recommendations were made by specialists, these were reflected in the care given.

Inspectors found that residents had access to appropriate medical support to meet their needs. The centres medical officer visited the centre five days a week and outside of this, GP services were provided by out-of-hours doctors. Residents were also supported to access national screening programmes if they qualified for them.

Inspectors reviewed a sample of care plans focusing on residents who were at risk of losing weight, residents who were high risk of falls, newly admitted residents, residents with behaviours that are challenging. Care plans reviewed were person centred in detail and were accompanied by relevant risk assessments. Assessments completed guided care plan interventions, including appropriate referrals to medical and allied health professionals.

The registered provider had ensured that the risk management policy and safety statement had been updated to minimise the risk of infection of COVID-19 to residents and staff working in the centre. Risk assessments with regard to abuse, unexplained absence of any resident, accidental injury to residents, visitors or staff, aggression and violence and self-harm, outlined the measures and actions in place to guide staff.

The COVID-19 contingency plan was informed by a comprehensive risk assessment. The risk register was updated with additional controls put in place to mitigate the risk of COVID-19 infection to residents, staff and visitors in the centre. They were subject to ongoing monitoring to ensure their effectiveness. Visiting was facilitated safely in line with the centres policy and national guidelines.

There was a risk assessment to identify potential risks when Seanchara opened and a detailed plan to guide staff to safely transfer residents. This also included ways to orientate residents to their new home for example memory boxes outside each room to identify bedrooms.

Infection prevention and control strategies had been implemented to effectively manage or prevent infection in the centre. These included implementation of transmission-based precautions for residents, ample supplies of PPE which were used in accordance with national guidelines and the monitoring of visitors and residents for signs of COVID-19 infection.

A seasonal influenza and COVID-19 vaccination program had taken place, with vaccines available to both residents and staff. There had been a high uptake of the vaccines among residents and staff. While there was evidence of good infection prevention and control practice, there was inappropriate storage and instances of poor hand hygiene which are further detailed under Regulation 27: Infection

Control.

While the premises was generally well maintained the following improvements were required to ensure the environment was safe and cleaning was effective. For example inappropriate storage of equipment, provision of hand hygiene sink in a clinical room, access to an assisted bathroom to ensure the privacy and dignity of residents in one shared room, and access to T.V's by all residents in shared bedrooms. This is described in more detail under Regulation 17: Premises.

The residents' committee met regularly and residents were seen to consulted with regard to the running of the centre. Their views and preferences were used to enhance the residents lived experience for example choices in how they spent their day. There were a variety of activities designed to meet each resident's interest and capacity. Residents had free access and movement around the centre and into the enclosed courtyard.

They had a choice of well-presented food with drinks and snacks available throughout the day. Residents were supported to exercise their civil, political and religious rights. An advocacy service was advertised in the centre and was available to residents on referral.

Residents' clothes were seen to be clean with laundry arrangements that ensured that residents' clothes were regularly laundered and returned to them. Residents had adequate space to store their belongings with a lockable space in their bedrooms. Improvement was required to ensure that residents had access and control over their monies held in safekeeping by the provider during out of hours times.

Staff interviewed were able to identify and respond to alleged, suspected or actual incidents of abuse. Staff told inspectors that they would report safeguarding concerns immediately to managers. However one cohort of staff had not had refresher training in the protection of vulnerable adults which is detailed under Regulation 16. Residents said they felt safe in the centre and spoke positively about the staff and care provided.

From a fire safety perspective, both buildings were reviewed in terms of the physical premises and the fire safety management systems in place. Inspectors found that the centre was laid out in manner that provided residents and staff with an adequate number of escape routes and fire exits. Alternative escape routes were available throughout.

Inspectors noted that both buildings were provided with an emergency lighting system, fire detection and alarm system and fire fighting equipment throughout. Records showed that fire fighting equipment, emergency lighting and fire detection and alarm system were being serviced at the appropriate intervals, however not all appropriate certificates were available for inspection in the centre on the day of inspection, and were subsequently submitted after the inspection.

The fire alarm system was an addressable L1 type system. Further assurances were required regarding the information displayed on the panel and the means for

alerting the other building in the designated centre should assistance be required in the event of a fire.

In the main both buildings were laid out with construction that would provide adequate containment of fire, however further assurance was sought during the inspection on the location of fire compartment boundaries. Inspectors observed evidence of work carried out to seal up gaps and breaches in fire rated construction. Further issues with excessive gaps to fire doors required further review. Fire doors to bedrooms were fitted with a 'swing-free' device connected to the fire alarm. This meant that residents were afforded the choice to leave their door either closed, fully open or ajar and door closers were not an impediment to their movement through the building.

In Clarehaven, staff spoken with were knowledgeable on the procedure to follow in the event of a fire and knew the assistance that would be required by residents during evacuation.

Improvements were required regarding information contained in the fire safety register for each building. For example, they did not detail the roles and duties assigned to staff in relation to fire safety and these sections were left blank.

Regulation 11: Visits

Visiting was facilitated in many areas in the centre and was well managed in line with national guidelines.

Judgment: Compliant

Regulation 12: Personal possessions

The provider was a pension agent for the collection three residents' social welfare pensions and this was managed well by the centre. However, while residents 'comfort funds' was kept safely by the provider, if resident wished, they did not have access to these funds outside of office hours. This impacted on residents rights to maintain control over their personal property.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider had ensured that Clarehaven premises was appropriate to

the number and needs of the residents in accordance with the statement of purpose. However the following were improvements required to ensure the needs and safety of the residents conformed to Schedule 6 of the regulations:

In Clarehaven:

- The provision of grab rails along both sides of corridor in Blue Haven to support residents to move safely through each side of the corridor.
- Inappropriate storage in assisted bathrooms such as crash mats, linen hampers, a walking frame, wheelchair. This meant that residents did not have adequate access to these bathrooms.
- Viewing of TV's in shared bedrooms were restricted where TV access, should residents be in their bed, could result in only be seen by one resident at a time.

In Seanchara:

- Toilet cabinets needed to be hung securely.
- The provision of security chains for medicine trollies was required.
- The provision of a call bell in one toilet should a resident require assistance.
- Door thresholds leading out to a number of courtyards were excessively high and could pose a potential trip when used.
- The provision of a clinical hand hygiene sink in the clinical room. A clinical hand hygiene sink is required where drugs and lotions may be stored and prepared, and where a supply of clean and sterile supplies may be held and dressing trollies prepared.
- Inappropriate storage in sluice rooms, for example an intravenous stand and weighing scales which could lead to cross contamination.
- The distance residents will need to travel from two of the bedrooms to an assisted bathroom was excessive. This could impact on these resident's rights to privacy and dignity.
- Viewing of T.V's in shared bedrooms was restricted, should residents be in their bed.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy met the requirements of the regulation. There were associated risk policies that addressed specific issues such as the unexplained absence of a resident, self-harm, aggression and violence, safeguarding and the prevention of abuse. There was a risk register in the centre which covered a range of risks and appropriate controls for these risks.

Judgment: Compliant

Regulation 27: Infection control

While there was evidence of good infection control practice outlined above, there were issues important to good infection prevention and control practices which required improvement:

- Staff hand hygiene practices required review as one staff were seen to wear a watch and another wore a stoned ring. This meant that they could not effectively clean their hands.
- More alcohol hand rub was required outside the dirty laundry holding area to support compliance with good hand hygiene practice.
- One medicines storage fridge was not clean, there was white residue on the bottom shelf.

Storage practices in the centre required review from an infection prevention and control perspective. For example:

- Sterile dressings were not used in accordance with single use instructions, they were stored with un-opened dressings and could result in them being re-used.
- A cleaner's trolley was stored in a sluice room which could result in cross contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were a number of areas of concern regarding the adequacy of fire precautions in the centre and improvements were required to comply with the requirements of the regulations to ensure that residents and staff were adequately protected from the risk of fire.

The registered provider was not taking adequate precautions against the risk of fire:

- In both buildings, staff were not informed of the correct fire compartment boundaries to ensure safe evacuation of residents
- In Clarehaven, issues identified with defective door closing devices were not addressed for four months. This was raised in the fire safety register by staff on a weekly basis, with no action by the provider to ensure they were functional.
- In Seanchara assurance was required regarding storage in a room containing electrical panels.
- In Seanchara the location identified for storing the oxygen cylinder was found

to be too small and would not be free of combustible items.

Inspectors were not assured that adequate means of escape was provided throughout the centre:

- In both buildings, additional escape signage was noted to be required in some areas to ensure directions of escape and exits were readily apparent. The signage in place did not correlate with the drawings accompanying the fire safety risk assessments. Some cross corridor doors were noted without escape signage above them to identify the escape route.
- In Clarehaven, key locks were noted to some exits. These exits were also fitted with electronic locks connected to the fire alarm system. The key locks were not locked during the inspection and inspectors were told they were never locked. While the risk of the doors being locked is low, inspectors did note a key in a staff area which could lock the exits. This was poor practice and required review.

From a review of evacuation drill records, inspectors were not assured that staff working in the centre were adequately prepared for the procedure to be followed in the case of fire and for the safe and timely evacuation of residents.

Inspectors were not assured that adequate arrangements were in place for containing fires. The buildings had recently been inspected by a third party fire safety consultant, and findings resulted in inspectors seeking assurance from the provider that staff were adequately prepared to execute the evacuation procedure, and that evacuation procedures reflected the compartment boundaries for horizontal evacuation.

- Assurance was required regarding the fire rating of attic hatches located within fire rated ceilings
- In Clarehaven, a door to an office on the bedroom corridor was not a fire door.
- In Seanchara, fire doors were noted to have excessive gaps where double doors met and gaps were noted to a compartment fire door.

Inspectors were not assured that adequate arrangements for giving warning of fires were in place:

- The fire alarm system was an addressable system, which means that the location of the fire will be displayed at the panel. The information displayed on the fire alarm panel, was not consistent with the day-to-day labelling of rooms used by staff. This may lead to delays in identifying the exact location of the fire alarm activation.
- The fire alarm systems for each building were interconnected and an activation in one building alerted at the panel in the other building. This consisted of a beep at the panel and if staff were not near the panel would not be alerted to provide support for evacuation.
- The procedure to summon assistance from the other building was not clear or adequately documented.

Improvements were required with the arrangements in place to evacuate where necessary in the event of a fire, of all persons in the designated centre:

- Staff confirmed they had participated in fire drills, however drill records confirmed that full compartment evacuation drills had not taken place and during the day or night.
- In Clarehaven, inspectors looked a sample of residents evacuation assessments, they did not include how many staff would be required to assist residents.
- In Seanchara, the mode of evacuation had not been fully thought out in advance of residents moving into the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were person centred and were reviewed regularly. There were effective systems in place for the assessment, planning, implementation and review of health and social care needs of residents.

Judgment: Compliant

Regulation 6: Health care

Suitable arrangements were in place to ensure each resident's well-being and welfare was maintained by a high standard of nursing, medical and allied health care. Residents had access to a wide variety of specialists and were accessing hospital care when required.

Judgment: Compliant

Regulation 8: Protection

Staff who spoke with inspectors were knowledgeable of the arrangements in place to protect residents and these included regular training sessions for healthcare staff and policies and procedures to guide and inform their practice.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that staff understood and respected residents' rights to make their own decisions and live in a way that suited them. They were consulted in the running of the centre where their voice were heard through resident meetings, interaction with staff and satisfaction surveys.

Judgment: 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 22: Insurance	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Clarehaven OSV-0007745

Inspection ID: MON-0033411

Date of inspection: 21/07/2021

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 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>A review of Clarehaven’s training schedule was conducted and all staff now completed their safeguarding training. Clarehaven’s training program covers all mandatory and essential training to equip all staff with knowledge and skills in the provision of safe, high quality person-centred care to the residents. This action was completed on 30/07/21.</p> <p>All department managers will conduct monthly audits on training records and any training requirement will be communicated to DON, PIC and Practice Development Coordinator.</p>	
Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <p>The staff file and all documents as referenced in schedule 2 have been sourced from the regional HR department and are now on file in the designated centre. Action completed on 30/07/21.</p> <p>An audit of all personnel files in Clarehaven was completed on 30th July 21 to ensure that every file meets the criteria in Schedule 2 and 4. This audit will be carried out by the Grade V staff every three months and quality checked by the Grade VII, who will provide assurances to the PIC/RPR that all files are complete and available in the designated centre. SOP developed for maintaining HR files to ensure ongoing compliance.</p> <p>A full review of training records conducted by DON and PIC to ensure that date, month and year of training is recorded and actions are in place to address any training needs or</p>	

gaps. Action completed on 30/07/21.

Regulation 23: Governance and management

Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- In order to ensure ongoing compliance all department managers will conduct a monthly audit on training records and any training requirement will be communicated to DON, PIC and Practice Development Coordinator.
- HSE fire officer conducted a review of fire compartments and PIC reviewed fire evacuation procedure based on the compartmentalization to ensure safe and timely evacuation of the designated center in the event of an emergency. Action was completed on 12/08/21.

• Maintenance requests that were not addressed at the time of inspection was completed on 19/08/21. To ensure ongoing compliance SOP created with following details to assure all maintenance requests are actively monitored.

1. All maintenance requests are logged on SAP Maintenance system by admin staff and a reference number from SAP Maintenance system is written on maintenance request sheet and filed in the Maintenance Report Folder that is located in the reception office of the unit.

2. A status white board is installed in the main admin office and jobs deemed as completed will be highlighted using a traffic light system and SAP Maintenance reference number, this will aid in jobs not being resubmitted when still active. Colour coding as follows:-

Red= New request active

Green= Completed

3. Admin staff are responsible for ensuring the request sheet is stamped with date job completed and filed in maintenance folder kept in Admin office.

4. A monthly audit is done by Admin staff to ensure all jobs are completed and signed off by the Services Manager.

Regulation 12: Personal possessions

Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

Resident's access to comfort funds has been reviewed to assure ongoing compliance. Center's property policy was reviewed on 03/08/21 and a small sum of money is available in a cash box in a locked filing cabinet for out of office hours, including weekends. Any money given to the resident during this time will be receipted by the person in charge on that day. A receipt book will be kept in the cash box for this purpose. On the next working day administration staff will be advised of the transaction and money will be reconciled with the resident's comforts and petty cash account. Action was completed on 03/08/21.

Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Clarehaven:

- Maintenance department is sourcing another set of hand rails and they will be fully installed by 30/11/2021.
- Inappropriate storage in the assisted bathroom has been removed on 23/07/21.
- A review of resident's choice and wishes to watch TV in their bedroom conducted and residents are happy with the current arrangements. In order to ensure ongoing compliance, residents choice will be reviewed and recorded as part of their activity care plans this will be completed by 17/09/21 and will be reviewed three monthly.

Seanchara:

- Toilet cabinets has been secured to the wall on 22/08/21.
- Medication trollies are secured with chain on 25/08/21.
- Toilet is for staff use and will be kept locked at all times.
- Height of door thresholds leading out to the courtyards have been reduced, action completed on 01/09/21.
- Location of the clinical room has changed to a new room which has a hand hygiene sink. This change is reflected on the SOP and floor plan, action completed on 08/09/21.
- Inappropriate storage from sluice rooms has been removed and these items are located in the store room on 23/07/21.
- Two bedrooms will remain closed to admissions until the shower unit is installed. This will be completed by 30/11/21.
- A review of resident's choice and wishes to watch TV in their bedroom conducted and residents are happy with the current arrangements. In order to ensure ongoing compliance, residents choice will be reviewed after the move and recorded as part of their activity care plans this action will be completed by 29/10/21 and will be reviewed three monthly.

Regulation 27: Infection control	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <ul style="list-style-type: none"> • Two members from nursing team has completed IPC link practitioner programme and are coordinating and conducting IPC audits, hand hygiene training and ongoing infection control awareness talks with staff. All staff in the center attended hand hygiene training this year. • Alcohol hand sanitizer installed outside the dirty laundry holding area on 23/07/21. • Medicine storage fridge cleaning regime reviewed and it is cleaned weekly and as required by night duty nurses. • Opened dressing materials were removed and discarded on 21/07/21. PIC and CNMs will continue to provide ongoing awareness on single use instructions. • Cleaner’s trolley removed from the sluice room and is stored in a storage container in an enclosed garden. Action completed on 05/08/21. 	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ul style="list-style-type: none"> • HSE fire officer conducted a review of fire compartments and PIC reviewed fire evacuation procedure based on the compartmentalization to ensure safe and timely evacuation of the designated center in the event of an emergency. This action was completed on 31/08/21. • Maintenance requests that were not addressed at the time of inspection was closed off on 19/08/21. To ensure ongoing compliance SOP created with details to assure all maintenance requests are actively monitored. • Fire officer provided assurance on 07/09/21 that materials can be stored beyond 2 meters of electrical panels. • Oxygen storage plan reviewed by PIC and Oxygen cylinder is stored outside in a secured area. Action completed on 27/07/21. • Fire exit signage was reviewed in both buildings by external fire safety consultants and additional fire exits signs were installed on 27/08/21. • In Clarehaven fire exits are operated with electronic locking system, some exits have an extra key locking system which can be used as an added security in the event of electric system fails. There is a risk assessment and SOP created to guide the staff about the exit locking system. PIC and CNMs will continue to provide ongoing awareness to staff regarding key locking system. Action completed on 30/08/21. • Fire evacuation procedure reviewed by PIC and Fire evacuation drill conducted weekly in Clarehaven simulating night time scenario with maximum number of residents and minimum number of staff. Repeated fire evacuation drill included all staff working in the center. Clarehaven had a fire training and evacuation drill conducted by external training company on 17/08/21. Action completed on 31/08/21. 	

- HSE estate confirmed 30minute fire rated stira attic ladders in place.
- Excessive gaps on the fire door rectified and action completed on 06/09/21.
- All rooms within Clarehaven and Seanchara have been given an asset number. A floor plan drawing giving the location of the rooms and asset number is located beside each fire panel. PIC/CNM2 will ensure staff are familiarise with these drawings. This action was completed on 02/08/21.
- Reviewed fire evacuation procedure now guide staff to alert and seek assistance from other building in the event of fire.
- PEEP template was reviewed and it now shows the number of staff required to assist resident during an evacuation. This action was completed on 02/08/21.
- Fire evacuation procedure in Seanchara was reviewed and mode of evacuation is bed evacuation however a ski sheet will be placed under each mattress for added safety. Action was completed on 31/08/21.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	03/08/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/07/2021
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	Substantially Compliant	Yellow	30/11/2021

	accordance with the statement of purpose prepared under Regulation 3.			
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.	Substantially Compliant	Yellow	30/11/2021
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Red	30/07/2021
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	19/08/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Substantially Compliant	Yellow	05/08/2021

	infections published by the Authority are implemented by staff.			
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	07/09/2021
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/08/2021
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	31/08/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/08/2021
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	Not Compliant	Orange	31/08/2021

	designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	06/09/2021
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	02/08/2021
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	31/08/2021
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	31/08/2021