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:	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:	17 April 2024
Centre ID:	OSV-0005053
Fieldwork ID:	MON-0043070

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, with 46 resident beds and 4 respite beds. 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. Each unit provides accommodation for 25 residents. There is an enclosed garden for resident's use adjacent to and behind the building. The family room is located on the first floor and there is an external designated smoking area for residents. 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:	46

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 17 April 2024	08:20hrs to 16:50hrs	Niamh Moore	Lead
Wednesday 17 April 2024	08:20hrs to 16:50hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

Residents provided positive feedback regarding life and care in Hollybrook Lodge. Inspectors observed that many residents chose to spend time in the numerous communal areas available for their use and staff were observed supervising these areas throughout the inspection. Comments from residents included that they felt safe in the centre, that the care they received from staff was good and they enjoyed the meals available.

The designated centre is located in Inchicore, Dublin 8. The centre is registered for 50 residents with 46 living in the centre on the day of the inspection. The building comprises two storeys with two units referred to as the Robinson Ward and Mary McAleese Ward. Each unit was set out across the ground and first floor, which were accessible by stairs and a lift. Residents' accommodation was located within the individual units in addition to communal spaces which were used as combined day and dining rooms. Additional communal space was available such as an oratory, a recreational and a multi-purpose room. There was access to the garden from the ground floor which residents could freely enter. Overall the premises was found to be clean and efforts to maintain a homely environment were evident.

Residents' accommodation was provided in 34 single, four twin and two four-bedded rooms, all with en-suite facilities. Bedrooms were observed to be personalised with ornaments, family photos and art work. They were clean and residents reported to be happy with their accommodation. However, inspectors observed that some residents did not have the minimum of 7.4 m2 of floor space and for some residents' living in multi-occupancy bedrooms there was insufficient privacy, which will be further discussed within this report. There were extensive delays in acting on issues referred for maintenance; for example inspectors observed that two dishwashers were faulty on the day of inspection.

Residents had opportunities and facilities to participate in meaningful activities in line with their interests and abilities. The designated centre had one dedicated staff member for activities and an activity planner was on display for residents' information. Activities were facilitated seven days a week in day rooms and also in the recreation room on the ground floor. On the day of the inspection, music was held in the morning time, with Mass available in the oratory in the afternoon. Residents' art work was displayed on corridors and in the recreation room, recent resident portraits completed by an external artist were drying prior to residents receiving their portraits. Information boards displayed information on advocacy services. A monthly newsletter was issued from the person in charge to residents and their nominated contact person.

The dining experience was observed in both units. Residents were supported to eat their meals in their bedrooms or in the dining room as per their preferences. Menus were seen to be displayed in each resident's bedroom, on the tables in the dining room and were also available on the tray for the residents which chose to have their

meals in bedrooms. There were sufficient staff on duty to provide assistance to residents if required, these interactions were observed to be kind and respectful. Residents were provided with a choice at mealtimes and inspectors observed residents' choices to be fulfilled. Tea, coffee, juice and snacks were provided outside meal times. Residents were complimentary about the food, with particular praise for the desserts.

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

Inspectors found that overall the management systems in place did not ensure that all residents received a service that was safe, appropriate, consistent and effectively monitored. Poor oversight found non-compliances with the regulations particularly in the areas of training, directory of residents, records, oversight of maintenance requirements and resources, auditing and contracts. Findings relating to the Quality and Safety of the service are further discussed under this theme.

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). This inspection also followed up on information of concern in respect of managing residents at risk of absconsion, and found that further action was required to ensure residents' safety was promoted at all times while upholding residents rights.

St James's Hospital is the registered provider of Hollybrook Lodge. The management team was established and included the provider representative who is the Chief Executive Officer of St James's Hospital, an Assistant Director of Nursing, an Operations Manager from the Medicine for the Elderly Directorate of St James's Hospital and the person in charge. The person in charge was supported by two clinical nurse managers (grade two), two clinical nurse managers (grade one), a catering manager, a cleaning supervisor and an activity coordinator. Inspectors were told that each of the two units were run at unit level by a CNM2 who carried out audits and monitored key performance indicators at a local basis. These units were overall run separately with limited input and oversight from the person in charge. The systems of oversight required strengthening to ensure there was a cohesive approach to care in both units in the designated centre.

Minor improvements were required to the statement of purpose to ensure it reflected the service operated and contained all information as required by the regulations.

Inspectors reviewed the training matrix for the designated centre and saw a suite of training was available to staff on areas such as a human rights-based approach, the

prevention and management of aggression and violence and restrictive practices. However, significant gaps were seen in attendance at mandatory training on safeguarding, infection control, manual handling and fire safety.

While formal supervision processes were in place to include supernumery management on site, induction forms, performance improvement plans and annual performance reviews, the day-to-day supervision provided to staff was inadequate. This was demonstrated by staff using resident areas for their break periods, inappropriate storage of staff food in residents' fridges, poor practices in respect of storage for residents' equipment, inadequate care planning arrangements for residents, all of which had not been identified by the provider's own auditing systems.

Inspectors were informed that the directory of residents was available for review on the electronic computerised system. However, the directory shown to inspectors did not contain any information for respite residents and information recorded for long term admissions did not meet all criteria as set out and required by the regulations.

There was poor oversight and management of records within the designated centre. This is further outlined under Regulation 21: Records.

Monthly and quarterly management meetings occurred with relevant management personnel from the designated centre. Key data relating to Hollybrook Lodge was discussed including an action plan developed with a lead person and timeframe identified. However, inspectors found that the governance and management systems in place did not ensure that overall residents received consistent care in line with their needs and that there was effective oversight of staff developmental needs. For example, one audit reviewed had an action plan due by February 2024 which referred to "completion by all staff to be confirmed" for safeguarding and infection control training. This was not in place on the day of the inspection. In addition, although maintenance was an agenda topic for these meetings, there was no follow up and no reference to any outstanding items; for example important pieces of equipment such as privacy screens had been reported to be in need of repair for more than one year and remained outstanding.

While an annual review was available and had been completed in line with the national standards, it did not meaningfully inform a quality improvement plan in respect of the centre. The registered provider had self-assessed themselves as meeting each standard. This was not in line with the findings of this inspection. There was no evidence of consultation with residents and no future planning arrangements.

There was inconsistency in contracts provided for residents admitted for short-term periods. Inspectors saw that one out of three such recent admissions had a contract in place. In addition, while long-term residents had information agreed in writing on their admission to the designated centre, including the fees on which they should reside in Hollybrook Lodge under, all necessary information was not contained within the contract. This is further outlined under Regulation 24: Contract for provision of services.

All incidents, as set out in Schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes.

The registered provider had a complaints policy in place which was revised in March 2024, however this policy was not in line with the procedures displayed throughout the designated centre. The person in charge told inspectors there was a low level of formal complaints received with all complaints managed through the informal processes of concerns. Inspectors reviewed a sample of concerns and could see they were recorded, appropriately investigated and concluded with the complainant's satisfaction level and any necessary learning recorded.

Registration Regulation 4: Application for registration or renewal of registration

A completed application for the renewal of the centre's registration had been received by the Chief Inspector prior to the inspection and was under review at the time of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that staff had access to mandatory and other relevant training to support them in their roles, in line with local policy and regulatory requirements. For example:

- One in three staff required refresher training in infection control.
- Three staff did not have any training in infection prevention and control.
- One in four staff required refresher training in fire safety.
- One in twelve staff required refresher training in manual handling.
- Three staff required first time training in manual handling.
- One in six staff required refresher training in safeguarding.
- Two staff required first time training in safeguarding.

Supervision of staff required strengthening. For example, there was ineffective oversight of clinical care which led to a number of poor findings and outcomes for residents, further detailed within the quality and safety section of this report.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents did not meet the criteria as set out within Schedule 3 of the regulations. For example:

- Not all residents were accounted for in the directory of residents. For example, residents admitted on a short-term basis to the designated centre were not included.
- While the name of the general practitioner (GP) was recorded for residents, the address and telephone number was not.
- The date a resident was discharged was missing for one resident out of four recorded discharges.
- The name of the designated centre or hospital a resident was discharged from was missing for two residents out of four recorded discharges.
- The time and cause of death was missing for 17 out of 39 recorded deaths.
- The name and address of any authority, organisation or other body which arranged the resident's admission was not recorded.

Judgment: Not compliant

Regulation 21: Records

Inspectors found that information governance arrangements within the designated centre were not robust. For example:

- Records were not retained for the required time frame. Inspectors were told that archived files for discharged residents were held on site for two years not seven years as outlined within the regulations.
- Records set out in Schedule 2 for housekeeping staff were not available for inspection.
- Incomplete information was identified in the documentation of Schedule 2 staff files. For example, a full employment history together with satisfactory history of any gaps in employment was not available for two out of three files reviewed.
- Progress notes in resident files were not comprehensive and in some instances omitted critical information pertaining to residents. This is further detailed within this report.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had a current certificate of insurance which indicated that

cover was in place against injury to residents and which met the regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

While inspectors noted there were sufficient resources available to ensure effective delivery of care and support in line with the statement of purpose, these resources were not deployed efficiently to ensure the impact on outcomes for residents is positive. Gaps in the oversight of the service of maintenance requests will be further discussed under Regulation 9: Residents' Rights and Regulation 17: Premises.

The management systems in place failed to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- Evidence of learning was insufficient to ensure any necessary improvements were brought about as a result of the findings of any reviews. For example, inspectors were told that following a period of unexplained absence of a short-term resident, control measures to be put in place included short-term residents to wear identification bands and pyjamas. These measures impeded on residents' rights to privacy, dignity and choice. Despite this incident occurring over seven days prior to the inspection, a critical incident review had not yet commenced to consider learning and put in place controls from the near-miss incident. Furthermore, inspectors observed numerous examples where window restrictors were broken, and these had not been reported. There was a lack of assurance that sufficient measures had been put in place to mitigate the risk of absconsion in the future.
- The person in charge did not have full knowledge and overview of the designated centre. Data collection took place at unit level and was not accurate and therefore inspectors could not be assured. For example, information provided on residents' data at the introductory meeting did not correlate with information reviewed in residents' care records.
- Analysis of information through audits occurring within the designated centre was not always leading to quality improvements. An environmental audit of November 2023 found 95 percent compliance. Environmental hygiene assessments of October, November and December 2023 identified no risks. This was not in line with inspectors' findings, especially in relation to inappropriate storage practices.
- There were inadequate precautions taken against risk. For example:
    - While access to piped oxygen was available in each bedroom, additional five cylinders of oxygen were found in a metal box at the end of one corridor on the first floor. This box was stored next to electrical battery charging points and in front of a means of escape located within a compartment that included residents' bedrooms. Review of oxygen storage was an action plan from previous inspection,

and while the provider had addressed the risk of collision and had put some controls in place such as signage and secure metal box, significant risk remained, which required further review.
    - In one unit the dishwasher had been broken for approximately two weeks, while in the other unit it was leaking and had been reported for more than 1 and a half year. Inspectors observed that staff used towels and continence sheets to prevent leakage and the floor in the kitchenette was significantly damaged as a result. This created a risk that dishes and utensils were not appropriately disinfected after use. Inspectors issued an urgent action in respect of dishwasher equipment and assurances were received on the day and following the inspection that corrective action had been taken.
    - In general environmental oversight and a proactive approach to risk management was not in place. The storage of chemicals was seen without sufficient controls in place. For example, cleaning equipment was seen stored unlocked within communal bathrooms and some resident bedrooms. Inspectors observed open creams and razors in residents' bathrooms, some of these had a diagnosis of dementia.
- Residents and or their families were not consulted with as part of the annual review of the quality and safety of care delivered to residents.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

All residents did not have written agreed contracts of care in place.

In a sample of three contracts reviewed, each contract does not have the type of bedroom set out in it, including the number of other occupants (if any) of that bedroom.

Judgment: Not compliant

Regulation 3: Statement of purpose

While the statement of purpose had been updated in April 2024, it required further review to contain all information set out in Schedule 1 of the regulations. For example, information on short-term residents and the organisational structure required review.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents were notified to the Chief Inspector in accordance with the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

While the registered provider had an effective procedure of dealing with complaints, the procedure on display throughout the building did not detail this clearly as it did not identify who the complaints officer and the review officers were, it did not detail what the complaints and review processes were for the designated centre.

Judgment: Substantially compliant

Quality and safety

Inspectors found that residents reported to be happy and that overall staff supported residents to receive a good standard of care. However, significant improvements were required in relation to care planning, health care and the oversight of premises and maintenance.

Inspectors reviewed a selection of residents' records such as validated assessments and care plans. While, some improvements in respect of the use of restrictive practices such as bedrails were noted, further action was required in respect of care planning arrangements to ensure they reflected the assessed needs of residents and to allow staff to provide appropriate care for residents. Numerous examples were seen where care plans had not been initiated within regulatory timeframes, or had not been updated at four monthly intervals. Similarly, validated assessment tools or care plans were not always updated following a change, such as following a fall.

Residents had access to medical care. A general practitioner (GP) attended the centre on a daily basis. There was evidence from a review of resident records that residents were reviewed by health and social care professionals with support available on site to medical services such as occupational therapy, physiotherapy, speech and language and community services such as chiropody. However, through a review of progress notes and observation charts, inspectors identified that residents were not always provided with a high standard of evidenced-based nursing. This is discussed further under Regulation 6: Healthcare.

The registered provider was facilitating human rights training for staff and some residents had human rights care plans in place, however inspectors saw examples where residents' expressed preferences were not always respected as staff did not know the content of the care plan. In addition, inspectors found that residents' rights to privacy were not upheld within the multi-occupancy bedrooms. The layout of the multi-occupancy rooms was open and had mobile privacy screens but one such screen was broken, one did not go fully around the bed to afford privacy and other screens were not seen in use during the day.

Inspectors viewed documentation in relation to residents' personal monies and found that there were appropriate procedures in place to safeguard residents' finances.

Overall, the physical environment was well-maintained. Communal areas were homely, bright and clean. Residents reported to be content with the lived environment of the designated centre. However, poor storage impacted on sufficient and effective cleaning. In addition, inspectors were not assured that the observed design and layout of all bedspaces within the four bedded bedrooms met the criteria of Regulation 17: Premises.

Mealtimes were observed to be a pleasant experience for residents. Inspectors found that residents were offered and had access to adequate quantities of food and drink that was properly prepared, cooked and served.

There were a number of good infection control processes within the centre. Overall the centre was clean, however the segregation of dirty and clean items and storage practices required further oversight. This is discussed under Regulation 27: Infection Control.

Regulation 12: Personal possessions

Each resident's personal property and finances were managed and protected. The registered provider was not a pension-agent. There was adequate safe and secure storage for residents' possessions in their bedrooms. Residents' clothes were laundered regularly with identifiable information attached to ensure that the items were returned to the correct resident.

Judgment: Compliant

Regulation 17: Premises

Inspectors found that action was required to ensure the premises conformed to all of the matters set out in Schedule 6. For example:

- The four bedded bedrooms were viewed by inspectors. Inspectors saw that one of these bedspaces in each bed room did not comply with the requirements of 7.4m2 of floor space, which area shall include the space occupied by a bed, a chair and personal storage space. For example, this space was seen to measure 6.47m2 which included the clinical handwash sink used by all residents of this room. This meant that residents of the other three bedspaces had to enter the private space of one resident to wash their hands.
- Enhanced oversight of maintenance was required as items requiring repair and replacement while reported on the maintenance log were not followed up to ensure the required response was taken in a timely manner. For example, on the day of the inspection the following was observed:
    - There were two faulty dishwasher machines within the centre
    - A residents' privacy screen was awaiting repair for one year
    - Numerous window restrictors were observed to be broken
    - A wall in a multi-occupancy room was severely marked and damaged
- While the centre had appropriate sluicing facilities, these were unsafe as the doors to each room were unlocked.
- There was inappropriate storage observed in assisted bathrooms, linen stores and general store rooms. These rooms were cluttered with numerous items on the floor, preventing effective cleaning of these areas.
- On the day of the inspection, inspectors observed staff using the oratory for their break, which was a designated area for residents. This was also noted in the previous inspection report of December 2023.

Judgment: Not compliant

Regulation 18: Food and nutrition

Where necessary, residents were assisted with their meals in a respectful and dignified manner. Inspectors observed that residents were provided with adequate quantities of food and drink. Residents expressed overall satisfaction with food and nutrition.

Judgment: Compliant

Regulation 27: Infection control

There were issues fundamental to good infection prevention and control practices which required improvement. For example:

- Cleaning schedules did not include the routine cleaning of fridges available in resident communal areas. Therefore two fridges were found to require

attention to ensure they were maintained in a hygienic manner. For example, food items were seen to be open and undated. In addition, one food item found in the fridge had an expiry date for the month prior to the inspection.

- Storage practices were inadequate and had the potential for cross-contamination. For example:
    - inappropriate storage of equipment such as wheelchairs and zimmer frames were seen within one communal bathroom
    - the trolley for holding clean linen was stored in the dirty utility room. Management told inspectors there was a process for ensuring this item was cleaned after use, however this process was not seen to be in place during the inspection.
    - clean linen such as bed sheets were stored within a room which also contained storage of Christmas decorations and residents' medical equipment.
    - toiletries such as talcum powder, toothbrushes and a razor were unlabelled and stored in the shared bathrooms of multi-occupancy rooms and therefore staff could not be assured who these items belonged to.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

In the sample of care plans reviewed, improvements were required to ensure that resident's received the care and supports required to maximise their quality of life. For example:

- Inspectors saw that care plans to meet the assessed needs of residents were not developed, for all residents reviewed, within 48 hours of admission as required by the regulation.
- Inspectors also observed that a number of care plans had not been reviewed within the timelines set out in the regulation. For examples, care plans were seen to date August 2022, September 2023, October 2023 and November 2023.
- A number of care plans were not personalised. For example:
    - A resident's care plan was in a template form and left incomplete with "blank" referenced in relation to their score on the assessment for their risk of falls and pressure ulcers.
    - A resident's continence care plan was not accurate. For example, this did not refer to the resident using a urinary catheter.
    - A resident's care plan had not been updated following a change in their resuscitation status.
    - A resident's falls risk had recently been updated, however their care plan had not been updated to ensure all staff were aware of how to meet the resident's current care needs.
    - Inspectors saw an occasion where a residents' preference for personal

care was not implemented in practice, and staff did not know the content of the care plan.
    - One care plan for a male resident made reference to another female name and therefore there was a lack of assurance that it was reflecting resident's individual needs.
    - There were no personalised care plans for short-term residents to respond to identified needs.This posed a significant risk and meant that opportunities to put appropriate safeguards in place were not considered in the care planning arrangements.

Judgment: Not compliant

Regulation 6: Health care

Inspectors found that improvements were required to ensure all residents' received a high standard of evidenced based nursing care. For example:

- A resident was not weighed weekly or referred to the dietitian in line with their risk of malnutrition assessed using MUST (Malnutrition Universal Screening Tool).
- Food records were not sufficiently detailed to provide all relevant and necessary information to allied health professionals regarding the residents' nutritional intake.
- Two hourly monitoring of bedrails was not seen to always occur.
- A wound care plan did not record key information relating to the wound to ensure sufficient detail was available to monitor progress or dis-improvement.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors observed that residents of the multi-occupancy rooms could not undertake personal activities in private.

- Residents were seen to be sleeping, watching television and having their meals within their bed spaces on the day of the inspection without privacy screens. Inspectors asked the person in charge to demonstrate the mobile privacy screen around a bed space and found this screen was not large enough to provide sufficient privacy.
- In addition, inspectors were told that another screen for one resident was broken. From a review of maintenance records, this screen had been broken for one year, which meant that this resident could not exercise choice and

their privacy needs had not been met since that time.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Hollybrook Lodge OSV-0005053

Inspection ID: MON-0043070

Date of inspection: 17/04/2024

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The person in charge shall ensure that staff have access to appropriate training.
The person in charge shall ensure that staff are appropriately supervised.

Hollybrook Lodge is committed and acknowledges its responsibility to ensure their staffs have the required competencies to manage and deliver person centred, effective and safe services to all residents. It is in this context that the following improvement actions have been agreed:

• Hollybrook staff training policy for mandatory regulated and essential training to be developed for all staffs.
• Improve staff uptake and attendance at mandatory and essential training appropriate to their scope of practice and at the required frequency with a focus on infection prevention and control, fire safety, manual handling and safeguarding.
• Improving the capture, sharing, reporting and monitoring of workforce training is currently an area of focus for improvement within Hollybrook Lodge.
• Process is underway by the Human Resources personnel for the update of the files for the in-house resident staffs
• Monthly mandatory reports for review by the PIC to now include all levels of staffs. PIC to monitor progress, identify and resolve attendance, and report deficits.
• Progress on mandatory training attendance deficits will be reported on a monthly basis at the local operational meetings and quarterly Residential Care Operational Quality Review Group forums.

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
The directory shall include the information specified in paragraph (3) of Schedule 3.

Hollybrook Lodge, as a provider, is responsible to ensure that there is an updated registry of residents details available at all times. It is in this context that the following improvement actions have been agreed:

• Record of registry reviewed and additional information such as GP, address and phone number added as per Schedule 3
• Review of directory of residents is now included in the Clinical weekly checks which will be performed by the PIC and also added into the daily checks performed by CNMs

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
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. Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre concerned.

Hollybrook Lodge will put processes in place to fully comply with above. It is in this context that the following improvement actions have been agreed:
• Plans to improve and ensure the Information governance arrangements will now include the installation of secure record-keeping and file management systems.
• From the date of inspection all residents' records will be maintained on premises for 7 years.
• New process initiated with the Human resources personnel for all staffs to update their curriculum vitae/application form to include explanations of satisfactory gaps in employment
• From the date of inspection all staffs' records to be maintained on premises for 7 years.
Development of a Hollybrook Lodge Quality monitoring and Assurance Process to address and standardise the documentation of all clinical nursing care

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: 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. The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families. Hollybrook Lodge are required to provide effective leadership and governance and to have management arrangements in place with clear lines of accountability. The quality of care and experience of residents needs to be monitored, reviewed and improved on an ongoing basis. It is in this context that the following improvement actions have been agreed: • All notifiable incidences to be locally reviewed and documented by the PIC and local nursing management team • Timely After action review meetings will be held by the PIC and attended by the Registered Provider/Designate, PPIM and any other stake holders to discuss High risk incidences. These meetings will be documented outlining controls put in place and relevant learning outcomes. • Guidelines to manage exit seeking behaviour within the centre to be developed. Post development, staff awareness programme to be delivered. • All staffs are made aware of the requirement to complete adverse incident report for a new admission into Hollybrook Lodge with pressure ulcer. Hollybrook Lodge's Admission policy to be updated outlining the same. • Audit process outlined for the centre will address and provide assurances to the PIC, PPIMs and Registered Provider Representative. • Daily operational huddle with multi-disciplinary team member is now embedded by the PIC to strengthening the overall governance and communication of the centre. • Monthly meeting is now scheduled between PIC and PPIM • Review of terms of reference of Residential Care Operational Quality Review Group is been undertaken • Following the inspection, a comprehensive review by the PIC and PPIM for any outstanding work for the facilities management team was undertaken and the following plans are in place to address same - New brackets ordered to store oxygen inside the clinic room- In progress - New Dishwashers in both units- Completed - New floor tile work for pantry- completed - Grease trap replacement in Pantry in both units- completed - Swipe access for sluice room- Completed - New Window restrictors installation for all residents' rooms- In progress - New curtains and mobile screens ordered- In progress - New filing installation requested to store residents' files- In progress - Linen room storage reviewed and clutter free- completed - Cleaning checklist in place for resident fridges- ongoing - Signage post for Residents utility space- completed	

- Storage room reviewed and order placed for more cabinets- In progress

• Environmental hygiene Assessment refresher training will be provided to CNMs on identifying and reporting risks. Environmental hygiene audit will be performed by the CNM 2 along with the catering manager as a joint approach to capture risks in all areas.
• An exercise to review Environmental hygiene assessment tool will be undertaken to ensure that it is meeting the needs of the residential centre's footprint.
• Resident's Care plan to include environmental safety checks, especially for those with cognitive impairment.
• The annual review of the quality and safety of care will be completed in consultation with families and residents in Hollybrook Lodge.

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.

Hollybrook Lodge is committed to ensuring that residents' contract of care is in compliance with the regulation. It is in this context that the following improvement actions have been agreed:

• Current contract of care for full review with legal and finance partners to reflect different accommodation
• Contract of care will now outline the specifics of different accommodation available to residents on admission
• Following the outcomes of inspection, the space in the 4 bedded unit is now converted to a 3 bedded and Hollybrook Lodge will now be operational as 48 bedded Long term care beds from 20/05/2024.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

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.

Hollybrook Lodge will ensure our statement of purpose is in compliance with regulations. It is in this context that the following improvement actions have been agreed:

• The Hollybrook Lodge's statement of Purpose to be updated to reflect all details set out in current compliance plan.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.

Hollybrook Lodge is committed to ensuring the local practices are in compliance with Regulation. It is in this context that the following improvement actions have been agreed:
• PIC reviewed the information leaflet to bring it in line with our current complaints procedure outlined with Statement of Purpose and Complaints policy. These leaflets are now available within the centre.

Regulation 17: Premises	Not Compliant

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

The registered provider will ensure Hollybrook's design and layout is suitable for its stated purpose. All areas in the premises to meet the privacy, dignity and wellbeing of each resident in a clean and safe environment that minimises the risk of transmitting a healthcare-associated infection. It is in this context that the following improvement actions have been agreed:

• Following the outcomes of inspection, the space in the 4 bedded unit is now converted

to a 3 bedded and Hollybrook Lodge will now be operational as 48 bedded Long term care beds from 20/05/2024.
• Environmental hygiene Assessment refresher training will be provided to CNMs on identifying and reporting risks. Environmental hygiene audit will be performed by the CNM 2 along with the catering manager as a joint approach to capture risks in all areas.
• PPIM to embed oversight to include Environmental hygiene assessments
• Following the inspection, a comprehensive review by the PIC and PPIM for any outstanding work for the facilities management team was undertaken and the following plans are in place to address same:
- New brackets ordered to store oxygen inside the clinic room- In progress
- New Dishwashers in both units- Completed
- New floor tile work for pantry- completed
- Grease trap replacement in Pantry in both units- completed
- Swipe access for sluice room- Completed
- New Window restrictors installation for all residents' rooms- In progress
- New curtains and mobile screens ordered- In progress
- New filing installation requested to store residents' files- In progress
- Linen room storage reviewed and clutter free- completed
- Cleaning checklist in place for resident fridges- ongoing
- Signage post for Residents utility space- completed
- Storage room with special seating reviewed and to remain clutter free- In progress
- Storage room reviewed and order placed for more cabinets- In progress
- New foldable chairs delivered to staff room. House rules to be strictly adhered to by all staffs on only utilising break rooms for break.
• Daily walk around by the CNMs, PIC and Staff Nurse incharge is now in place to ensure premises are clutter free
• House rules to be strictly adhered to by all staffs on only utilising break rooms for break. The same. Staff induction booklet with house rules will now be in place for all staffs within the Hollybrook Lodge.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Hollybrook Lodge will ensure to have effective leadership, governance and management arrangements in place with clear line of accountability. The quality of care and experience of residents will be monitored, reviewed and improved on an ongoing basis. Hollybrook Lodge premises will meet the privacy, dignity and wellbeing needs of each

resident and care will be provided in a clean and safe environment that minimizes the risk. It is in this context that the following improvement actions have been agreed:

• Develop a weekly cleaning checklist for all fridges within Hollybrook Lodge (clinical and non clinical). This will be completed by staffs on the unit. CNMs to audit this new practice on a weekly basis.
• Following the inspection, a comprehensive review by the PIC and PPIM of the centres storage facility has been undertaken. Plans are being developed in collaboration with the finance and facilities department to utilise the storage facilities more effectively and the following actions are in place to address same
- Storage room with special seating reviewed and to remain clutter free- In progress
- Storage room reviewed and order placed for more cabinets- In progress
- New filing installation requested to store residents' files- In progress
• Environmental hygiene Assessment refresher training will be provided to CNMs on identifying and reporting risks. Environmental hygiene audit will be performed by the CNM 2 along with the catering manager as a joint approach to capture risks in all areas.
• An exercise to review Environmental hygiene assessment tool will be undertaken to ensure that it is meeting the needs of the residential centre's footprint.
• Post the inspection, processes are embedded to safeguard residents especially those with cognitive impairment. Personal care items were labelled and stored appropriately and same is now documented in residents' person centred care plan.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).

PIC will oversee and ensure care plan is completed based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned and reviewed at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Hollybrook Lodge is committed to ensure each residents' care plan to include comprehensive assessment of their needs in line with a person centred approach. It is in this context that the following improvement actions have been agreed:

• Hollybrook Lodge Quality monitoring and Assurance Process to be developed

• Daily review of residents nursing assessments and care plans to be completed by nurse managers with their team members. Outcomes of these reviews to be reported to the PIC on a daily basis.
• PIC to complete monthly audits on residents nursing assessments and care plan.
• Process of nursing documentation reviewed and developed in line with a person centred approach to ensure residents are included in the entire process. This change in process is now embedded into every day's practice.
• Review of residents' assessments and care plans has been undertaken and errors and omissions addressed
• The process of verbal handover at the commencement of shift has now changed to include to reflect residents' individual needs.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.

Hollybrook Lodge is committed to deliver high-quality evidenced based practice and ensure it is well documented in the residents records. It is in this context that the following improvement actions have been agreed:

• Hollybrook Lodge Quality monitoring and Assurance Process to be developed to identify risks, provide assurances and contribute to Quality Improvement Plan
• Daily review of residents nursing assessments and care plans to be completed by nurse managers with their team members. Outcomes of these reviews to be reported to the PIC on a daily basis.
• PIC to complete monthly audits on residents nursing assessments and care plan.
• Process of nursing documentation reviewed and developed in line with a person centred approach to ensure the resident is included in the entire process.
• All staffs within the Hollybrook Lodge have equal opportunity to access all training programmes internally (within St. James Hospital)/externally to continuing professional development relevant to their roles. Through local PPD processes, we will ensure staffs are encouraged to utilize this opportunity. Records of staff training attendance and their PPD folders are maintained for all nursing and HCA staffs locally.
• Following the inspection, re-education programme will be delivered focussing in the following three areas:
- MUST policy
- Bed rail policy
- Pressure ulcer prevention and management policy.
Practices in these three areas will be audited and included in the Hollybrook Lodge's Quality monitoring and assurance process.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.

Hollybrook Lodge is committed to deliver high-quality evidenced based practice and ensure it is well documented in the residents records. It is in this context that the following improvement actions have been agreed:

• Hollybrook Lodge Quality monitoring and Assurance Process to be developed to identify risks, provide assurances and contribute to Quality Improvement Plan
• Daily review of residents nursing assessments and care plans to be completed by nurse managers with their team members. Outcomes of these reviews to be reported to the PIC on a daily basis.
• PIC to complete monthly audits on residents nursing assessments and care plan.
• Process of nursing documentation reviewed and developed in line with a person centred approach to ensure the resident is included in the entire process.
• All staffs within the Hollybrook Lodge have equal opportunity to access all training programmes internally (within St. James Hospital)/externally to continuing professional development relevant to their roles. Through local PPD processes, we will ensure staffs are encouraged to utilize this opportunity. Records of staff training attendance and their PPD folders are maintained for all nursing and HCA staffs locally.
• Following the inspection, re-education programme will be delivered focussing in the following three areas:
- MUST policy
- Bed rail policy
- Pressure ulcer prevention and management policy.
Practices in these three areas will be audited and included in the Hollybrook Lodge's Quality monitoring and assurance process.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/05/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2024
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	Orange	14/06/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	24/05/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in	Not Compliant	Orange	14/06/2024

	Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre concerned.	Not Compliant	Orange	30/09/2024
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.	Substantially Compliant	Yellow	30/09/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	14/06/2024
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in	Not Compliant	Orange	30/09/2024

	consultation with residents and their families.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Not Compliant	Orange	14/06/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/09/2024
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	31/05/2024

Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Substantially Compliant	Yellow	30/09/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	24/06/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	22/05/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared	Not Compliant	Orange	14/06/2024

	under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	14/06/2024
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.	Not Compliant	Orange	30/09/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident	Not Compliant	Orange	30/09/2024

	may undertake personal activities in private.			