

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	Hollybrook Lodge
<b>Centre ID:</b>	OSV-0005053
<b>Centre address:</b>	St Michael's Estate, Bulfin Road, Inchicore, Dublin 8.
<b>Telephone number:</b>	01 416 2587
<b>Email address:</b>	ceopa@stjames.ie
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	St James's Hospital
<b>Provider Nominee:</b>	Lorcan Birthistle
<b>Lead inspector:</b>	Ann Wallace
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	45
<b>Number of vacancies on the date of inspection:</b>	1

## **About monitoring of compliance**

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
01 June 2017 13:30	01 June 2017 21:00
02 June 2017 10:00	02 June 2017 11:30

The table below sets out the outcomes that were inspected against on this inspection.

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This was an unannounced inspection by the Health Information and Quality Authority [HIQA]. The purpose of the inspection was to monitor ongoing compliance with the Health Act 2007 [Care and Welfare of Residents in Designated Centres for Older People] Regulations 2013 [as amended] and the National Standards for Residential Care Settings for Older People in Ireland. The inspector also considered information received by the Authority and notifications submitted relating to suitable staffing, health and social care needs and privacy and dignity. The inspector investigated these areas and found that the concerns relating to suitable staffing and health and social care needs were unsubstantiated and the concern relating to privacy and dignity was being managed by the centre.,

There were 45 residents in the centre during the inspection and one vacancy. The centre was divided into two units. McAleese unit on the first floor and Robinson's Unit on the ground floor. All residents were residing in the centre for continuing care

apart from 2 respite residents. The centre provided care for residents with complex needs and requiring a high level of nursing care and support.

The inspector met with residents, relatives, the person in charge, a provider representative and nursing and care staff. The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

Inspectors found there were effective governance and oversight arrangements in place. There were sufficient resources to ensure the delivery of care was in accordance with the Statement of Purpose and there was a clearly defined management structure in place. However during the inspection the organization of the staff resources on one unit did not ensure that staff were able to meet residents needs at all times and some residents received their medication outside of the recommended time frames.

The building was warm and comfortably decorated and visually clean. Fittings and equipment were clean and generally well maintained however there was an ongoing issue with the window safety restrictors and closures throughout the building and with the roller blinds in some bedrooms.

Residents spoken with stated that they felt safe in the centre. A range of activities was facilitated by the activities coordinator who worked with nursing and care staff to provide a range of activities and outings for residents. This was a particular strength of the centre.

A total of 11 Outcomes were inspected. Seven outcomes were judged as compliant with the regulations and of the remaining Outcomes, one was judged as substantially in compliance with the regulations and three outcomes were judged as moderate non-compliances.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Compliance with Section 41(1)(c) of the Health Act 2007 and 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.**

***Outcome 01: Statement of Purpose***

***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The inspector found that there was a written statement of purpose that accurately describes the facilities and services that were provided in the centre. The statement of purpose reflected the ethos of care in the centre. The document had been updated following the last inspection and contained all of the information required by Schedule 1 of the Health Act 2007 [Care and Welfare of Residents in Designated Centres for Older People] Regulations 2013 [Amended 2016].

**Judgment:**

Compliant

***Outcome 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The inspector found that there were systems in place to monitor the quality of care and experience of the residents in the centre.

The service provided in the centre was seen to be in line with the statement of purpose. The inspector found that there were sufficient resources made available to provide safe and effective care and services for residents.

There was a clearly defined management structure that identified the lines of authority and accountability, and all staff with whom the inspector spoke were clear about the reporting structure. The person in charge [PIC] was supported in her role by the clinical nurse managers [CNM] on each of the units.

The centre is part of the St Jame's Hospital Elderly Medicine Directorate and is represented in the hospitals clinical governance and corporate governance committee structures. These structures provided good oversight in key areas such as audits, incidents and complaints and quality improvements. Senior management meetings were held monthly. The PIC met with the senior management team within the directorate on a regular basis.

Documentation showed that the quality of care and the experience of residents were monitored and reviewed on an ongoing basis. There was a residents forum which was chaired by the activities coordinator and an annual unit based resident survey was completed in 2016 and was reported in the centre's annual report. There was clear evidence of changes being made in response to audit and quality reports and to resident feedback. These included improvements to the activities programme and menus.

As part of the ongoing governance within the centre the senior nursing team carried out a range of monthly audits on practice in each unit and used the findings to identify areas for improvements. Areas audited included complaints, incidents, care plans, medications, use of bedrails and falls.

The inspector found that the centre had appropriate arrangements in place to supervise staff in their work. Nursing and care staff were supported and supervised in their day to day work by the unit clinical nurse managers. The clinical nurse managers worked a flexible roster in order to provide support and supervision at weekends and out of hours when required.

Support staff in catering and housekeeping were supervised by the heads of departments for those areas.

Annual appraisals were in place for staff. There were regular staff meetings including staff handover meetings at the beginning of each shift. All meetings were minuted. Staff told the inspectors that they had regular contact with the PIC and the CNMs in the centre and that senior staff were approachable.

**Judgment:**  
Compliant

***Outcome 03: Information for residents***  
***A guide in respect of the centre is available to residents. Each resident has an***

***agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The inspector found that the centre provided each resident with a resident's guide which provided relevant information about the services and facilities in the centre. The inspector reviewed a sample of residents' contracts and found that the contract set out the services to be provided and all of the fees being charged to the resident. The contract had been updated following a requirement from the last inspection.

**Judgment:**

Compliant

***Outcome 05: Documentation to be kept at a designated centre  
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Although this outcome was not investigated during this inspection the inspector found that

- 1] There were a number of residents on both units who did not have a recent photograph in their records.
- 2] Fluid balance charts and nutritional intake records were not up to date for some residents.

**Judgment:**

Substantially Compliant

**Outcome 07: Safeguarding and Safety**

***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The inspector found that appropriate measures were in place to safeguard and protect residents from abuse.

The centre had comprehensive policies and procedures in place to guide practice in the prevention, detection and response to abuse. Staff were able to articulate the different types of abuse as described in the centre's policy and were clear about what to do if they suspected or were informed about an allegation of abuse and who to report it to. Staff training records showed that staff had attended safeguarding training and that regular update training was available to staff.

Senior nursing staff were familiar with the procedures to follow to carry out an investigation and what their role would be.

Residents who spoke with the inspector said that they felt safe in the centre.

The inspector reviewed the policies and procedures that were in place in the centre relating to responsive [challenging] behaviours and the use of restraint. Policies and procedures followed national best practice guidance and the centre was working towards a restraint free environment. Staff had attended training on the management of responsive behaviours. Care plans were in place for resident's who presented with responsive behaviours. Staff knew the residents who may present with these types of behaviours and how to respond to the individual residents in order to support them and keep them safe.

Where restraints were in use, for example bed rails, residents' records showed that a comprehensive risk assessment had been completed and that alternatives had been considered. Care plans showed that residents and their families were involved in the decision to use restraints. Restraints were monitored by the centre and residents' care plans relating to restraints were reviewed at least four monthly.

**Judgment:**

Compliant

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The inspector found that in some areas the health and safety of residents, staff and visitors was actively promoted; however not all risks identified in the centre had been addressed at the time of the inspection.

The centre had a comprehensive health and safety and risk management policies in place which met the regulations. There was an up to date Health and Safety Statement which was centre specific and detailed the processes that were in place relating to health and safety. The centre had an emergency plan in place which provided guidance to staff on the contact numbers and the alternative accommodation for residents should a full evacuation of the centre be required.

The centre's risk register was updated regularly. The register risk rated individual risks and documented the measures that had been put into place to mitigate any impact on residents, staff and visitors. However the inspector found that not all risks had been managed effectively during the inspection including;

- 1] The door to the utility/cleaning room did not close securely
- 2] The medicine trolley was left unlocked and unattended when a nurse was called away to answer a call bell.
- 3] Some bedroom doors were held open by waste bins. Staff reported that this practice also occurred at night if a resident requested to have their door open through the night.
- 4] Several windows throughout the centre did not have effective opening restraints fitted. Repairs to the windows had not resolved the issues and the inspector noted that some windows would not close securely, others would not stay open when needed and one window in a ground floor bedroom opened to its full extent creating access to the centre's outside garden area and posing potential safety and security risks to the resident. This was discussed with members of the senior management team at the feedback meeting who agreed to progress the issue.
- 5] The inspector found that there were number of residents who did not have a recent photograph in their records. This is actioned under Outcome 5.

The inspector noted that a number of these risks had been identified in the previous report.

Training records showed that staff had access to a range of health and safety training

including moving and handling, infection control and fire safety. Staff who spoke with the inspector demonstrated a good awareness of health and safety issues and were able to articulate specific risks relating to their work and the measures that were in place to manage that risk.

Records showed that fire drills were carried out regularly and included a night time scenario. Staff interviewed demonstrated that they knew what to do in the event of a fire including the center's evacuation procedures. Fire action signs were on display throughout the building. Evacuation sheets were available for those residents who were identified as needing full support during an evacuation. Each resident had a personal emergency egress plan [PEEP] which clearly outlined the resident's needs in terms of mobility, communications and cognitive impairment in the event of an emergency evacuation. Maintenance records confirmed that fire equipment was serviced regularly.

Staff were observed to follow the centre's infection control guidelines. The inspector found that staff washed their hands regularly and wore personal protective equipment such as aprons and gloves. Hand sanitizers and hand washing facilities were in place around the centre.

Records showed that the centre had a programme for servicing equipment. Staff reported that equipment was repaired or replaced promptly when required.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The medication policy gave clear guidance to nursing staff on areas such as the individual responsibilities, the 'ten rights', ordering, administration including that of 'as required' [PRN] medication, crushing medication and the disposal of un-used and out of date medications. Policies and procedures reflected national best practice guidance.

A sample of resident's medication records was reviewed. The records were signed by the nurse following administration of medications and the record included the name of the drug and dosage and the time of administration. There was space to record if a drug had not been administered and the reason why was documented using a coded system. Drugs that were crushed for administration were prescribed by the centre's medical staff as suitable for crushing and liquid alternatives were sourced where

possible. Residents' medications were reviewed regularly by the resident's general practitioner [GP].

The inspector observed part of a medication round and found that some practices were not in line with the centre's own medication policies and best practice guidance.

- 1] Nursing staff signed the medication record before the medication was administered.
- 2] Another medicine was signed for although the medication notes reported that the resident had refused the medication.
- 3] The inspector also noted that the nurse was called away on two occasions during the medications round to deal with other residents. The medicine trolley was left unlocked and unattended.
- 4] The medicines for 2 residents were administered outside of the acceptable time scales for prescribed medications.

Medicines were stored safely in locked medication trolleys. Controlled drugs were stored securely. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked the controlled drug stock balances on McAleese unit with a member of staff and found them to be correct.

**Judgment:**

Non Compliant - Moderate

***Outcome 11: Health and Social Care Needs***

***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Each resident had an assessment of their needs, care plans that described how their needs were to be met and individual resident's care needs were reviewed on a regular basis.

The inspector reviewed a selection of resident's records during the inspection and spoke with residents and their families about the health and social care services provided in the centre. Residents and their families reported that care needs were met and that they were kept informed about care plans and any changes that occurred.

Resident's needs were assessed prior to admission and again on admission. A comprehensive care plan was developed following admission. Records showed a good standard of risk assessment and care planning for example nutritional risks, pressure sore risk and falls risks were completed for each resident. Care plans identified resident's self-care abilities and their preferences for care and services for example what time they liked to get up and what activities they enjoyed. Risk assessments were in place to ensure that care was delivered safely whilst promoting individual resident's independence.

The resident record was kept at the end of the resident's bed. The record included the residents care plan and daily progress record including a record of when care staff delivered specific aspects of care such as repositioning a resident or supervising individual residents with fluids and diet. These were completed by care staff and checked by the nurse in charge of each shift. However during the inspection the inspector found that fluid input and nutritional care charts were not up to date for some residents.

Resident care plans were reviewed four monthly or more frequently if a residents condition changed. There was evidence that residents and their families were involved in the reviews if they chose to attend.

Records showed that resident's had access to general practitioner [GP] services. The person in charge informed the inspectors that residents could keep their own GP if they wished to do so. GPs visited the centre on a regular basis and there were arrangements in place for out of hours GP services should a resident need an urgent medical review.

A range of allied health care professionals attended the centre and records showed that relevant allied health professionals were contacted as required including dietician, speech and language therapy, palliative care services and mental health services. The centre organized optical and dental services for residents when required. Where recommendations were made for individual residents they were put into place for example mobility aids/adaptations and modified diets.

Feedback from residents and their relatives during the inspection was positive about the quality of healthcare that they were provided with in the centre.

**Judgment:**

Compliant

***Outcome 13: Complaints procedures***

***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Complaints were being recorded in the centre. Complaints were being listened to and acted upon.

The centre had a comprehensive complaints policy in place. The policy clearly outlined the processes in place to make a complaint, who to go to and what could be expected from the centre to manage the complaint. The complaint policy was displayed at various points throughout the centre. Staff were able to articulate the procedure for making and dealing with complaints.

The inspector reviewed the complaints log with the person in charge [PIC] and found that written and verbal complaints had been recorded. The document included the actions taken by the centre to resolve the complaint, the outcome of the complaint and the complainant's satisfaction with the outcome. The complaints log was reviewed monthly as part of the centre's monthly through the centre's quality improvement programme. Records showed that complaints that could not be dealt with at the level of the centre were escalated to the senior management team in the directorate for elderly care. The PIC informed the inspector that the centre used the learning from complaints to make relevant changes and improvements such as staff training or changes in activities and menus.

**Judgment:**

Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***

***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The inspector found that there was a person centred approach to the residents in the centre that respected their privacy and dignity. However the inspector found that the window blinds in a number of resident's bedrooms were in need of repair. Staff reported that this is an ongoing issue in the bedrooms throughout the centre. The inspector noted that repair times and the quality of the repair work to the window blinds did not

ensure that resident's privacy was protected at all times. This was discussed with members of the senior management team at the feedback meeting who agreed to progress the issue.

Throughout the inspection residents were seen to be making choices about their day to day life at the centre. For example when to get up, what to eat and drink at meal times, where to spend time in the centre and what activities to take part in during the day. There were televisions, radios and newspapers available for residents to access.

Where residents had communications needs these were identified in their assessment and care plans and staff were familiar with the most effective way to engage with individual residents. Staff demonstrated empathy and respect in their dealings with individual residents.

Residents were offered a range of recreational activities to meet their needs and preferences. The centre had a planned activities programme which was organised by a dedicated activities coordinator. The programme included 1:1 and group activities. Residents were seen mobilizing around the unit on their way to the various activities on offer. The inspector observed residents and their families attending a music session in the first floor lounge. A number of residents and some relatives joined in and performed during the session as other residents called out encouragement and congratulations on the performances. The activity created a real sense of community and fun. During the inspection residents and their families reported a high level of satisfaction with the activities programme and the inspector noted that it was a particular strength of the unit.

There were regular residents meetings and records showed that topics such as meal choices and activities in the centre were regularly discussed.

Residents were supported to engage in religious activities of their choice. Mass and communion were available in the centre. Staff were aware of individual residents religious preferences and needs and were respectful of same.

There was access to advocacy in the centre and details were provided in the resident's guide.

Residents were supported to vote in elections if they wished to do so.

**Judgment:**

Non Compliant - Moderate

***Outcome 18: Suitable Staffing***

***There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act***

**2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.**

**Theme:**  
Workforce

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The inspector found that there was an adequate complement of nursing and care staff on duty during the inspection. Staff had the skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the purpose and size of the designated centre. The inspectors noted that the planned staff rota matched the staffing levels on duty. However during the inspection the organization of the staff resources on one unit did not ensure that staff were able to meet residents needs at all times and some residents received their medication outside of the recommended time frames. This was discussed with the PIC and the senior management team at the feedback meeting who agreed to address the issue.

There was a policy for the recruitment, selection and vetting of staff. The person in charge [PIC] informed the inspector that all staff working in the centre had current Garda vetting in place.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. The inspectors found that in addition to mandatory training required by the Regulations, staff had attended training on infection control, care of residents with dementia and end of life care.

There was also evidence of staff reviews taking place with annual appraisals being completed and probation reviews for new staff. The PIC implemented the centres performance review procedures to manage under performance when required.

**Judgment:**  
Compliant

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

***Report Compiled by:***

Ann Wallace  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Hollybrook Lodge
<b>Centre ID:</b>	OSV-0005053
<b>Date of inspection:</b>	01 June 2017
<b>Date of response:</b>	5 July 2017

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 05: Documentation to be kept at a designated centre

#### Theme:

Governance, Leadership and Management

#### The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A number of residents did not have a recent photograph in their records. Fluid balance charts and nutritional intake records were not up to date for some residents.

#### 1. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**

All residents have a recent photograph in their healthcare records

The requirement to invite residents to have their photograph taken and saved as part of their healthcare record has been integrated to the Centre's Admission procedures.

Admission policy and admission records updated to reflect this requirement

Requirement to maintain accurate current records of nursing care is directed in the Centre's Policy.

Record keeping included in Nurses' Continuous Education Programme

Compliance with requirements for record keeping is added to Centre's audit schedule

Proposed Timescale: Completed

**Proposed Timescale:** 05/07/2017

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

1] The door to the utility/cleaning room did not close securely

2] The medicine trolley was left unlocked and unattended when a nurse was called away to answer a call bell.

3] Several windows throughout the centre did not have effective opening restraints fitted.

All of these risks had been identified in the previous report.

**2. Action Required:**

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**

Repair of the utility/cleaning room scheduled for week beginning 10.07.2017

Fitting of restraints to windows scheduled for week beginning 17.07.2017

Medication Policy identifies requirement for nursing staff to secure medication trolley in the event they are interrupted when undertaking medication administration.

-Awareness promoted by Nurse Managers.

-Medication Safety Audit process amended to include the assessment of nursing practice when they are interrupted during their medication rounds.

**Proposed Timescale:** 31/07/2017

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Some bedroom doors were held open by waste bins. Staff reported that this practice also occurred at night if a resident requested to have their door open through the night.

This risk had been identified in the previous report.

**3. Action Required:**

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**

Meeting held to discuss Centre's Fire Safety arrangements on 03/07/17. Attended by Chief Operations Officer, the MedEl Management team and Director of Facilities. The following actions agreed :

- Source alternative mechanisms for holding door ajar that can be more easily removed in the event the door needs to be closed quickly e.g. in the event of a fire.
- In collaboration with SJH Fire Safety Officer revise the Centre's Fire Response Plan to accommodate door closing in the event an alarm is activated. Communicate and practice revision with staff, residents and family / carers where appropriate.
- Post this revision consult with HSE Estates (Owners of Building) as necessary regarding requirements.

**Proposed Timescale:** 31/07/2017

**Outcome 09: Medication Management**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

- 1] Nursing staff signed the medication record before the medication was administered.
- 2] Another medicine was signed for although the medication notes reported that the resident had refused the medication.
- 3] The inspector also noted that the nurse was called away on two occasions during the medications round to deal with other residents. The medicine trolley was left unlocked and unattended.
- 4] The medicines for 2 residents were administered outside of the acceptable time

scales for prescribed medications

**4. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**

Medication Policy identifies requirement for nursing staff to document the administration of medication accurately and comprehensively i.e. signing once medication is administered to the individual resident not when medication dispensed.  
-Policy and training updated to include the "dot to pot" medication safety initiative i.e. the nurse records a dot on the Resident's kardex when the medication is dispensed into the medication pot. A signature or appropriate record e.g. refusal, is only added once the medication has been administered.

Medication Trolley unattended - As previously addressed in Outcome 08

Medication policy identifies requirement for nursing staff to administer medications at the "right time" and as prescribed.

- Staff advised regarding their responsibility to effectively delegate tasks to ensure they are administering medications as per policy
- Strong teamwork ethic promoted within the Nursing teams and encouragement given to ensure staff utilise all available resources to them.
- Ongoing audit of local practice by the CNMs to monitor the timings of medication rounds in accordance to the scheduled administration timings on resident's kardex.

**Proposed Timescale:** 31/07/2017

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The medication trolley was left unlocked and unattended.

**5. Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

**Please state the actions you have taken or are planning to take:**

Medication Trolley unattended - As previously addressed in Outcome 08

Proposed Timescale: Completed

**Proposed Timescale:** 05/07/2017

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The window blinds in a number of bedrooms were in need of repair.

**6. Action Required:**

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**

A complete list of broken/ absent blinds within the Lodge collated and provided to the Facilities department.

All blinds to be repaired/ replaced as required.

**Proposed Timescale:** 31/07/2017