

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Hollybrook Lodge
Centre ID:	OSV-0005053
Centre address:	St Michael's Estate, Bulfin Road, Inchicore, Dublin 8.
Telephone number:	01 416 2587
Email address:	ceopa@stjames.ie
Type of centre:	The Health Service Executive
Registered provider:	St James's Hospital
Provider Nominee:	Lorcan Birthistle
Lead inspector:	Mary O'Donnell
Support inspector(s):	Conan O'Hara;
Type of inspection	Unannounced
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	0

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.

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 Quality 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 1 day(s).

The inspection took place over the following dates and times

From: 10 November 2015 10:00 To: 10 November 2015 18:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Major
Outcome 14: End of Life Care	Substantially Compliant
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

Hollybrook Lodge was registered as a designated centre for older persons residential care in August 2015. It is governed and managed by the MedEl directorate with St James's Hospital. Prior to this St James' Hospital provided sub-acute transitional care to fifty patients at Hollybrook Lodge. The sub-acute service was transferred to Unit 4 at St James' Hospital and the people in residential care in Unit 4 were transferred to Hollybrook Lodge. The transfer of residents and the residential service commenced in August 2015. In order to meet the needs and preferences of the residents the transition was undertaken on a phased basis and completed in October 2015. This was the centre's first inspection since it became a registered designated centre. The unannounced inspection was carried out by two inspectors over one day. The purpose of the inspection was to monitor compliance with the regulations and

standards and to follow up on unsolicited information received by the Authority. As part of the inspection, the inspectors met with the person in charge, staff members, residents and relatives. The inspectors reviewed policies and procedures, care plans, staff files and other records in the centre.

The person in charge was on extended leave and the person in charge who replaced her was found to have the appropriate experience and knowledge to carry on the role of person in charge. Inspectors followed up on the 11 action plans from the registration inspection. Two action plans were completed, seven were progressed and two had not been addressed.

The statement of purpose had been revised in line with regulatory requirements. A refurbishment plan had been drafted to provide additional communal and recreational space and create a homely environment for residents. Approval had been granted to recruit a full time activity coordinator. Staff had participated in mandatory training to protect and safeguard residents from abuse. However the policy had not been updated as required. Policies and procedures had been revised and were in draft format awaiting sign off. The risk management policy had been amended but further work was needed to meet regulatory requirements.

The provider and person in charge were working towards changing the environment within the centre to support a social model of care in line with the regulations and national standards. However the medical model of care was still very evident. Residents spent most of their time by their bedside with little to occupy or engage them during the day. Concerns for the safety of residents impacted on their freedom of movement within the centre and residents could not go outside without being accompanied by a relative as there was no secure garden. End of life care plans reflected the wishes of the residents but overall assessments and care plans did not support the involvement of residents or their representatives. They were pre-printed and lacked sufficient detail to support the consistent delivery of holistic person-centred care.

Arrangements were in place to facilitate the involvement of residents and their representatives in decisions about their care and the organisation of the centre were in place, but no residents' meetings had taken place since the move to Hollybrook Lodge as there was continuous dialogue with both the residents and their relatives during the move. There was evidence that some issues raised by relatives were acted upon but complaints were not documented or managed in line with the policy. This merited a judgment of major non compliance with the regulations. Relatives claimed that inadequate staffing levels were the root cause of the problems with care provision. Inspectors saw that there was a rich skill mix with more nurses than health care attendants on duty. Staff were sometimes rushed but it was not possible to determine if the deficits in service provision was due to inadequate staffing or inflexible, task orientated routines. It was evident that a change in the culture of care was needed and staff required training to support them to make the necessary transition to a more social model of care.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.

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 Quality 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 inspectors reviewed the statement of purpose which accurately described the service that was to be provided in the centre and minor amendments had been made to reflect Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The Statement contained a description of the premises including the dimensions of the various rooms. Staffing levels included auxiliary staff, which were expressed in whole time equivalents as required. Arrangements for the management of the designated centre when the person in charge is absent from the centre were documented.

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):

No actions were required from the previous inspection.

Findings:

Inspectors read a copy of the residents' guide and found that it reflected the facilities

and the services provided in the designated centre. However the copy of the guide shown to inspectors did not have information about the procedure respecting complaints and did not include the updated arrangements for visitors. The guide was not made available to the residents.

A copy of the updated 'Residents Information Booklet' which was submitted following the inspection contains information relating to complaints and visiting arrangements.

Contracts of care did not contain details of the fees to be charged. The person in charge told inspectors that this fee had yet to be agreed with the relevant body.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The Person In Charge (PIC) of the designated centre was on extended leave and a Clinical Nurse Manager 3 (CNM3) was nominated to deputise as the PIC in her absence. The PIC was present throughout the inspection and she was interviewed by inspectors.

Inspectors were satisfied that the PIC of the designated centre was a suitably experienced nurse with authority, accountability and responsibility for the provision of the service. She is a registered nurse with relevant experience to hold the post. The PIC demonstrated the required knowledge and expertise regarding caring for older people and has specialist knowledge in relation to bone health and falls prevention. The PIC works on a full-time basis and demonstrated a good knowledge and understanding of the role.

There were suitable deputising arrangements in place for when the acting person in charge was on leave.

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):

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

Findings:

The centre maintained records, and had recording systems and procedures in place to support the provision of safe services to residents. As noted at the previous inspection some of the operational policies and procedures listed under Schedule 5 of the regulations were not specific to the centre and were more relevant to the acute hospital setting where the centre was previously located. The inspectors were satisfied that this was a work in progress and some of the policies viewed had been amended and were now centre specific.

Policies and procedures which were not available during the previous inspection were available in draft form, awaiting approval and sign off. Some policies examined by inspectors, required additional work in order to meet regulatory requirements. For example the policy on ' Responding to Emergencies' required more detail including personal emergency plans for each resident. The risk management policy did not include self-harm, nor did it reference the unexplained absence of a resident as required under Regulation 26.

Staff recruitment was undertaken by the HR department in the acute hospital. Inspectors reviewed a sample of staff files and found that they contained all the information required by Schedule 2 of the Regulations.

Inspectors found that not all records listed under Schedule 4 were maintained in the centre. Inspectors found that not all complaints were recorded. In addition complaints recorded did not document the action taken and the satisfaction of the complainant.

As detailed in Outcome 8 the records of incidents and accidents were held in a central office and were unavailable for inspectors to read.

Inspectors also noted that not all records were easily accessible, for example training records were not easily accessible on the day of inspection and were submitted and reviewed afterwards.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Inspectors found that there were reasonable measures in place to protect residents from being harmed or suffering abuse.

The 'patient/resident protection policy' had not been updated to address the issue identified at the previous inspection. The policy still referenced the 'Trust in Care, 2005' instead of the more recent HSE policy on the safeguarding of vulnerable adults in residential care (December 2014). The PIC told inspectors that a medical social worker from St. James' Hospital facilitated 'Abuse Awareness and Response' training on a monthly basis and the CNM2 was responsible for ensuring that all staff attended this mandatory training. All staff interviewed during the inspection confirmed that they had attended the training, they had the knowledge to discuss various types of abuse and the action they would take to report suspicions or if they witnessed abuse. The PIC and managers had an appropriate knowledge of the policy in order to respond to a report of abuse. Inspectors saw that a small number of new staff were scheduled to attend training on 12 Nov 2015.

Inspectors saw that residents had a drawer with a lock for the safekeeping of money and valuables. Each unit also had a secure safe for residents use. Inspectors found there were robust systems in place for the safeguarding of residents monies. All transactions were documented and signed by the resident where possible and witnessed by two staff. Inspectors cross checked a sample of accounts and found them to be correct.

The policy on the use of restraint reflected the national policy. The policy for managing behaviours that challenge was being revised and not available for inspectors. Inspectors found that there was minimal use of restraint and staff worked towards creating a restraint free environment. Bedrails were the only restrictive device in use. Some residents had bedrails for safety reasons or because they requested them as a mobility aid. All residents were risk assessed before bedrails were used and there was evidence that less restrictive measures were trailed such as movement alarms and low-low beds with crash mats. Some residents used only one bedrail so as not to curtail their freedom of movement. The use of bedrails was subject to ongoing review and overall the care

plans reviewed outlined how often residents with bedrails were to be checked.

Practice in relation to working with residents who had behaviours that challenge was not in line with current best practice. The policy was not available for inspectors to read. Some residents had behaviours that challenge and staff told inspectors that the most common behaviour was verbal outbursts. These residents were in a four bedded room to facilitate the supervision of the residents. Inspectors monitored the residents for periods throughout the inspection and found that they were confined to a room with little or no stimulation, which did not constitute a therapeutic environment for the residents. Although constant 24 hour supervision ensured that physical risks to their safety were mitigated, the risk of boredom which may trigger the behaviours had not been considered. Two televisions were on in the room and residents were observed to be either in bed or sitting by their bedside. Apart from eating or drinking the residents were not involved in activities nor offered stimulation or meaningful engagement in order to meet their social needs. There was little or no resources available to support staff to occupy or engage residents. One resident was observed to play with her slipper for a prolonged period. There was no documentary evidence that residents had been assessed to determine any underlying cause or triggers that may precipitate the behaviours and residents did not have individual care plans to guide staff in order to provide a consistent therapeutic approach to caring for these residents. The person in charge told inspectors that staff had training in 'non violent crises intervention'. Inspectors found that staff had not done an assessment to determine the reason or the emotion underlying the behaviour in order to develop behavioural support plans for these residents.

Judgment:

Non Compliant - Moderate

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 inspectors evidenced that the centre had prioritised the health and safety of residents, visitors and staff. However, the risk management policy did not contain all of the information required by the Regulations. Records of incidents and accidents were not available for inspectors to read. The action plan relating to this is under Outcome 5. The Acting Person in Charge told inspectors that there were very few accidents, incidents or falls. The accidents or incident forms are completed and submitted to a central office and a periodic report is generated about accidents, incident and falls in the

unit. This report has not yet been generated for the centre.

Inspectors examined the risk management policy and found it did not fully comply with Regulation 26 as it did not adequately detail or cross reference the measures and actions in place to control: abuse, the unexplained absence of any resident, accidental injury to residents, visitors & staff, aggression and violence and self-harm. Residents were assessed for risks such as falls, malnutrition pressure sore risk and they had care plans to address the risks identified. The safety statement covered clinical and non clinical risks and the control measure to mitigate the risks. An established system for the management of risk is in place since the centre commenced operating. The risk policy statement which is being developed will include the controls in place to minimise identified risks in line with regulatory requirements. The centre has a risk register which included most but not all the environmental and clinical risks. The new risks identified for Hollybrook Lodge related to staff training and security.

Inspectors found that fire safety precautions were in place. Fire escapes and exits were marked clearly and were not obstructed. Inspectors observed that fire extinguishers, alarms, detection equipment, fire blankets were available throughout the centre. A visitors book was also maintained in the reception of the centre to show who was in the building in the event of an emergency.

Staff in the centre were trained in safety practices. Inspectors examined staff training records and found that training had been provided to staff in areas such as manual handling and fire safety. The training records examined by inspectors showed that these were up to date for all staff.

An emergency plan was in place for the centre which provided guidance for staff on what to do in the event of any emergency. If the centre needed to be evacuated the hospital emergency plan would be implemented.

There were measures in place to control and prevent infection and inspectors observed that the centre was clean and well maintained. Inspectors observed that cleaning equipment was easily available and supplies of personal protective equipment, such as, latex gloves and aprons were available throughout the centre. There were adequate hand-washing facilities and sanitising hand gel was available in key areas of the centre and used appropriately by staff. Cleaning staff had appropriate knowledge of their roles and responsibilities in relation to infection control.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Not all notifications submitted to the Authority were submitted in accordance with the timeframes outlined in the regulations. For example the notification (NF20) submitted in October 2015 related to an event which occurred in April 2015. The quarterly notification (NF39) which should include information about the use of restraint, did have any information about bed rail usage. The Authority holds the view that if a resident has a lap belt or bedrails which he/she is unable to independently release, this is a form of restraint.

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):

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

Findings:

It was evident that the service prioritised the provision of high quality medical and nursing care to residents. A medical model of care was evident and nursing assessments and care plans did not guide person centred care or fully support the involvement of the resident or their families in the development of their care plans. As identified in the previous report, the social aspects of care were an area for development. The service had begun to address this by training staff in life story work in order to support staff to get to know each resident as a person. Some staff had begun to work with residents and their families to create life story books. The books contained pictures and details of the resident's significant life events, their family life and their interests and hobbies. This initiative was in its early stages and a culture change was required to support and sustain the project. This is discussed in detail and related action plans are included under Outcome 16.

There were suitable arrangements in place to monitor and meet the health and nursing needs of residents. The social needs of residents were not evident in the nursing

assessments or the care plans developed in line with residents' changing needs. Residents and their families, where appropriate were involved in planning their end of life care but overall there was minimal involvement of residents in the care planning process. Systems were in place to prevent unnecessary hospital admissions and the nutritional and hydration needs of residents were met.

Residents had access to medical practitioners and to allied healthcare professionals including dietetic, physiotherapy, speech and language, dental, ophthalmology and podiatry services. The centre also had access to the mental health of later life services, with onsite visits from consultant led psychiatry of later life team. Residents had access to occupational therapy assessments and residents were provided with suitable seating to meet their specific needs.

Inspectors found that the vast majority of residents in the centre had dementia or a related cognitive impairment and they tracked the journey of a number of residents with dementia. They also reviewed specific aspects of care such as nutrition or wound care in relation to other residents.

Residents had been transferred to the centre from the residential unit in St. James Hospital. There was documentary evidence that a nurse manager assessed prospective residents prior to admission to ensure that the service could adequately meet their needs. Residents' files held a copy of their hospital discharge letter and detailed the assessments undertaken by a geriatrician, a medical social worker, and assessments by allied health professionals and a comprehensive nursing assessment.

Residents had a nursing assessment based on the activities of daily living on admission. The assessment included the use of validated tools to assess each resident's risk of malnutrition, falls, level of cognitive impairment and their skin integrity. A care plan was developed within 48 hours of admission, based on the residents assessed needs. Assessments were repeated and care plans updated routinely on a three monthly basis or to reflect the residents' changing medical and nursing care needs. Inspectors found that tick boxes were used in 'activities of daily living' assessments and there was very little evidence of residents or relative's involvement in the assessments or that their wishes and priorities informed their care plans. Care plans were pre-printed and did not provide sufficient detail to guide person centred care. For example the care plan for a resident who required a fluid chart did not state the recommended daily fluid intake.

A number of residents were admitted to the centre with pressure ulcers. Inspectors tracked wound care for two residents and found their wounds were managed in line with the policy and both wounds were healing.

Residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, medications reviewed and care plans were updated to include interventions to mitigate the risk of further falls.

Inspectors noted that staff were competent to undertake intravenous canulation and to administer subcutaneous fluids to treat dehydration in order to avoid unnecessary hospital admissions. The file of a resident availing of respite care showed that he had a comprehensive review and had commenced treatment for a medical condition which was detected on admission. This had been an issue in the registration inspection.

Residents with diabetes were appropriately monitored and managed. Inspectors found the staff adhered to the HIQA guidance of blood glucose monitoring. Residents with diabetes were managed by the medical officer and referred to the diabetic clinic where appropriate

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

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

Findings:

This centre was purpose built over 10 years ago and it provided single bedroom accommodation for the majority of residents. However communal space for residents use was limited and the centre had a clinical rather than a homely ambience. Over 90% of the residents had dementia and the provider had engaged an expert from the Dementia Services Information Centre to draw up a refurbishment plan for the centre which, when implemented would greatly improve residents' quality of life and optimise functioning of residents with dementia.

The design and layout of the centre was in line with the statement of purpose. Inspectors found that the premises and grounds were clean and well maintained. The majority of residents had a single bedroom; with two twin rooms and one four bedded room on each floor. There was a wheelchair accessible bathroom on each floor and the bedrooms had en suite facilities with contrasting grab rails to optimise the functioning of residents with cognitive impairment and visual impairments.

Staff told inspectors that they encourage families to personalise the residents' bedrooms. Inspectors saw that some rooms were personalised with photographs, pictures and soft furnishings. Each room had an accessible functioning call bell. The floor coverings throughout the centre had a matt sheen which was appropriate for people with dementia. There was no use of contrasting colours or signage to help residents to find their way around or to identify their bedroom. Inspectors read the proposed refurbishment plan with included unique identifying features on bedroom doors, and the use of contrasting colours to make toilets and bathrooms more easily

identifiable to residents with dementia or those with visual impairment.

Communal space was limited especially for residents on the first floor, who had one communal/dining room which they preferred not to use. Some residents went downstairs to attend musical entertainment in the afternoon but the majority of residents spent the day and took their meals in their bedrooms. The refurbishment plan included curtains on the windows and homely furniture for this room. Inspectors saw that fire places which had been purchased for the day rooms on both floors. There was greater scope for creating communal space on the ground floor. There were plans to develop the former therapy rooms into a beauty room and comfortable sitting rooms for residents. Grab rails were installed in communal areas to support residents to move around. However within the centre free movement was restricted somewhat by locked internal doors and residents did not have free access to the external environment because the garden was not secured.

There was no designated smoking area for use by one elderly resident who smoked. This resident has health problems and is exposed to any inclement weather conditions while being wheeled outside to smoke. This requires review to ensure this resident's needs and wishes are met.

Residents had access to assistive equipment such as a standing and built in hoists and pressure relieving mattresses. Arrangements were in place for the regular servicing and maintenance of equipment.

Judgment:

Non Compliant - Moderate

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:

The centre had a complaints policy on the management of complaints and information was available for residents and visitors. Inspectors found that not all complaints were documented and residents were not provided with details of independent advocacy services.

The complaints policy was an organisational policy and outlined in detail how to make a complaint and the procedure for dealing with the complaint and what the complainant could do if they were unhappy with the outcome. Leaflets providing a summary of the

complaints policy were available in the foyer and in each unit. However, the policy was not implemented in practice. Inspectors reviewed the complaints log and it was evident that staff and managers in the centre did not record all complaints made or document the responses and outcomes to these complaints. Inspectors were also made aware of issues raised by residents and relatives which were not documented as complaints. Some of these issues were resolved, some were being progressed and others were being investigated but this was not documented. The process of learning from complaints and ensuring issues did not reoccur was not evident as they were not being appropriately recorded.

The person in charge confirmed that none of the residents were currently availing of advocacy services. Inspectors found that residents were not provided with details of how to access independent advocacy services and no information on advocacy was on display in the centre.

Judgment:

Non Compliant - Major

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Staff provided end of life care to residents with the support of their medical practitioner and the community palliative care team. Nobody was receiving end of like care at the time of inspection.

The inspectors reviewed a number of 'End of life' care plans that outlined the physical, psychological and spiritual needs of the residents, including residents' preferences regarding their preferred setting for delivery of care. The resuscitation status of each resident was documented and resident who were not for resuscitation had end of life care plans in place. Single rooms were available for end of life care. Residents are prayed for at Mass following their death and staff confirmed that they attend funerals of deceased residents.

Areas for improvement were identified for example a resident who wished to return home did not have a plan detailing how this would be arranged. Residents who were for resuscitation did not have an end of life care plan in place.

Judgment:

Substantially Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Fresh jugs of water were placed in residents rooms daily and there were water stations in the main corridors on both floors.

Food was prepared in the central kitchen in St. James' hospital and the menus had been reviewed by a dietician. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and weekly when indicated. Nursing assessments focused on the residents' ability to eat independently, the level of assistance required and information about residents likes and dislikes were not sought or documented. Nutritional care plans were in place that outlined the recommendations of dieticians and speech and language therapists where appropriate. Nutritional and fluid intake records when required were appropriately maintained. Inspectors joined residents having their lunch in the dining room, and saw that a choice of meals was available. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on diabetic and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served. Residents who spoke with inspectors were satisfied with the times that meals were served. Staff and residents told inspectors that they could access snacks and beverages at any time.

Relatives told inspectors that they sometimes assist residents with meals because of inadequate staffing or the risk of meals being cold by the time staff were available to assist residents to eat. Inspectors noted that the household staff distributed the lunch to residents in their rooms and then health care assistants or nursing staff came to assist residents who could not eat independently. It is likely that meals could be cold if staff that were to provide assistance were delayed. This system should be reviewed to ensure that all residents enjoy meals which are served at the correct temperature and receive timely assistance as required.

From conversations with household staff it was evident that many residents were not offered choices from the menu. One staff member explained that she knew what

residents eat and what they won't eat. She described how she tried to vary the meals for residents who were on altered consistency diets. 'Residents on a minced moist diet can have mince or fish. If they had mince yesterday I will give them fish today'. Menus were not displayed and picture menus may better support residents with dementia to make food choices.

There was opportunity to improve the social aspects of mealtimes. On the ground floor thirteen residents took their lunch in the dining room and the remaining residents dined in their bedrooms. Visitors told inspectors that there would normally have been very few residents using the dining room on Robinson Unit. In the McAleese unit on the first floor nine residents were in bed for their lunch, nine ate their lunch sitting by their bedside and four residents ate in the dining room. Overall it was a solitary experience with residents seated at separate tables or at the opposite end of a table. Meals were hot when served and the CNM was seen to urge staff to provide timely support and assistance. Two volunteers called 'Plate Pals' came to the units and sat with a resident to provide companionship while the resident ate their meal. This initiative was positively evaluated, with residents eating better when 'Plate Pals' were present. The inspector saw positive interactions between staff and residents in both dining rooms. However the seating arrangements did not support social interaction between residents. The acoustics in the room coupled with the background noise of the tables being cleared, the dishwasher motor and the TV made conversation very difficult. Residents told inspectors that they preferred not to use the dining room for meals. The person in charge told inspectors about plans to include soft furnishings to absorb sound and create a more homely room for residents to use. The action plan around this is included under outcome 16.

Inspectors tracked the care of a resident who had a percutaneous endoscopic gastrostomy (Peg tube) and found that the care plan directed the resident's care in relation to the management of the tube and the feeding regime. The resident who had unintentional weight gain, had recently been referred for a dietetic review.

Judgment:

Substantially 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:

Inspectors found that the residents' forum which supported the involvement of residents in decisions about their care and the organisation of the centre had not been activated since residents moved to the centre. Residents did not have information about advocacy services. However there was evidence that a hospital social worker undertook an advocacy role by supporting a resident to collect her pension and make lodgements to her savings account. Inspectors saw evidence that residents' right to refuse treatment or medications was respected. Families advocated for residents and the person in charge told inspectors that concerns about too few TV channels had been actioned and satellite channels will soon be available to residents. As detailed in Outcome 13, the issues raised by residents were not recorded and there was no documentary evidence that issues were followed up to ensure that improvements were sustained. A relative who complained that her mother was in bed for prolonged periods without receiving attention told inspectors that the matter was addressed at the time but they suspected the practice still continued. Inspectors noted that a large number of residents spent prolonged periods in bed. Data about the number of residents who spent prolonged periods in bed was not collected as part of the audit of the quality of care.

Staff respected residents' dignity by knocking on doors before entering resident's rooms and providing privacy for personal care. There was little evidence of flexibility in daily routines however, and this impacted on the dignity of residents. For example relatives reported that residents sometimes had to wait their turn to have their incontinence wear changed.

Systems to promote safety impacted on the residents' independence. For example residents identified as being at risk of falls who were not under the immediate supervision of staff had magnetic motion alarms attached to their clothing and sat by their bedside in their rooms. Locked internal doors prevented residents from walking around freely. Inspectors saw that until lunch time, both ends of the corridors in the two units had linen trolleys, laundry skips and at least four safety signs indicating that the floors were wet. Consequently very few residents walked in the corridor. Staff told inspectors that families sometimes took residents into the garden but the centre did not have a secure garden which residents could access independently because the gates could not be locked for fire safety reasons. There was no sheltered external area for smokers.

The centre had an oratory and residents were facilitated to attend weekly religious services there. Inspectors did not see any newspapers, books or magazines in the centre. There was no evidence that communication aids or specialist equipment was available to support the residents with communication problems. One resident who was hearing impaired told an inspector that she had lost both of her hearing aids since she was admitted to the centre. When the inspector followed up with staff it was evident that the lost hearing aids was never reported or responded to by staff.

Visiting times were unrestricted and this was confirmed by staff and visitors. Facilities for occupation and recreation were inadequate and activities were dictated by the routine and resources of the centre, not the wishes and interests of the residents. The physiotherapist facilitated a weekly exercise class. Volunteers offered manicures and a

resident's son entertained residents with music which they clearly enjoyed. Residents' records showed that the predominant activity which residents engaged in was watching television. This had been identified by the provider and, as noted in other outcomes, the centre is in the process of advertising for a full time activity therapist. The refurbishment plan when completed would provide more communal and recreational space for residents.

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 Authority received unsolicited information about inadequate staffing levels in the unit. Relatives who met with inspectors also expressed concerns about staffing levels and its impact on the quality of residents' lives. The acting person in charge told inspectors that the dependency levels of residents was used to determine staffing needs. On the day of inspection there was a rich skill mix on duty, but inspectors found that staff were sometimes rushed and focused on the completion of care tasks rather than meeting the holistic needs of the individual residents. It was not possible to determine if this was a cultural issue or if the staffing levels did not fully support the delivery of holistic nursing care.

There were separate staff assigned to each unit and teams were led by two nurse managers who were supernumerary. There was a planned staff roster in place, with any changes clearly indicated. The staff working on the day of inspection was reflected in this roster. Review of the staff rosters for each unit indicated that there were four nurses on duty from 8:30 hours until 16:30 hours, three on duty until 21:00 hours and two nurses on night duty until 8:30 hours. There were three health care assistants (HCA) on duty from 8:30 hours until 16:30 hours and two HCAs on duty from 16:30 until 08:30 hours. In McAleese Unit an agency provided 41 hours of HCA cover on a daily basis and 48 hours on Robinson Unit in order to supervise residents with behaviours that challenge who were deemed to need constant supervision.

Staff were allocated to various teams to look after residents in allocated rooms and they tended to spend periods working with the same residents in order to provide continuity of care. Inspectors attended the afternoon handover meeting which was attended by nurses and care assistants. Staff were reminded of the resuscitation status of each resident and given updates on the specific nursing care issues, for example, wounds dressed, diet taken and if the resident had a shower or an assisted wash. Staff who spoke with inspectors had knowledge of all the residents nursing and healthcare needs and they said they got to know the residents from talking with them. When HCAs were asked about residents who could not communicate verbally they knew little about the resident's background and life they had led prior to admission to the centre.

Many of the staff were long term employees who moved with the residents when the centre opened. Some new staff had also been recruited and the recruitment procedures in place met the regulatory requirements, and included Garda vetting. The orientation programme for new staff supported them in their roles. Staff told inspectors that the mentoring and orientation programme equipped them for their role in providing care for residents. Staff were supervised appropriate to their role, and regular appraisals were also conducted.

Inspectors observed staff delivering care in a respectful manner but at times seemed task orientated and appeared rushed.

Staff used wheelchairs to transport residents who could not walk and inspectors noted that staff were not seen to assist residents who required support to walk. Relatives told inspectors they were sometimes told that they would have to wait their turn when they told staff that a resident required personal care. Residents who moved from shared bedrooms to single room accommodation are at risk of social isolation and staff were not competent to assess or meet the social needs of residents. The acting PIC told inspectors that the centre had received approval to recruit a full time activity coordinator who would support staff to provide activation and meet the social needs of residents. Interviews and training records confirmed that staff had up to date mandatory training. Some staff had training on dementia care.

Volunteers visited residents in the centre on a regular basis to support activity provision. Garda clearance was sought for all volunteers and appropriate arrangements were in place for the supervision of volunteers.

Judgment:
Substantially 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:

Mary O'Donnell
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 report¹

Centre name:	Hollybrook Lodge
Centre ID:	OSV-0005053
Date of inspection:	10/11/2015
Date of response:	01/12/2015

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 03: Information for residents

Theme:

Governance, Leadership and Management

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

The residents guide was not made available to residents.

1. Action Required:

Under Regulation 20(1) you are required to: Prepare and make available to residents a guide in respect of the designated centre.

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

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

Provide each Resident with a copy of their individual Hollybrook Lodge Care Guide which includes the following documents / information:

- Hollybrook Lodge Residents Information Booklet
- Hollybrook Lodge Statement Of Purpose
- Individual Resident's Contract of Care
- Hollybrook Lodge Complaints Procedure
- List of Key Contacts

Proposed Timescale: 31/12/2015

Theme:

Governance, Leadership and Management

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

The contract of care did not include details of the fees to be charged.

2. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

Revise the Centre's Contracts of Care to include details of the agreed Cost of Care fees for the Centre.

Provide updated Contracts of Care to each Resident

Proposed Timescale: 31/12/2015

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:

Policies required review in order to meet regulatory requirements.

3. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

Continue to review and develop centre specific policies in accordance with the requirements stated in regulation 4(3) referred to in regulation 4(1) which includes the following:

- Communication with Residents
- Responding to Emergencies
- Personal Property , Finance & Possessions Management
- Risk Management policy
- Complaints Management policy

Proposed Timescale: 30/06/2016

Theme:

Governance, Leadership and Management

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

Many of the policies were not centre specific

The complaints policy was not implemented in practice

4. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

- Continue to review and develop centre specific policies in accordance with the requirements stated in regulation 4(1) which includes the following:
 - Communication with Residents
 - Responding to Emergencies
 - Personal Property , Finance & Possessions Management
 - Risk Management policy
 - Complaints Management policy
- Provide staff with additional information, training and support in the effective management of complaints in accordance with the Centre's updated Complaints Management Policy

Proposed Timescale: 30/06/2016

Theme:

Governance, Leadership and Management

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

Not all the records listed in Schedule 4 were kept in the designated centre and available for inspection.

5. Action Required:

Under Regulation 21(1) you are required to: 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.

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

Ensure that Hollybrook Lodge staff have access to complete, accurate and current records as set out in Schedules 2, 3 and 4 (Health Act - Regulation 21(1)) including the following:

- Records of all staff training
- Records of any incidents / accidents that occur in the Centre

Proposed Timescale: 29/02/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Staff had not done an assessment to determine the reason or the emotion underlying the behaviour in order to develop behavioural support plans for these residents.

6. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

Provide staff with access to the following resources to improve their competency in assessing, responding and managing behaviour that is challenging:

- Updated centre-specific Challenging Behaviour Management Guidelines
- Improved access to allied health staff to assist them in assessing, planning and delivering care for Residents with behaviour that is challenging
- Additional education, training and support in assessing, planning and delivering care for Residents with behaviour that is challenging

Proposed Timescale: On-going

Proposed Timescale:

Theme:

Safe care and support

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

The 'patient/resident protection policy' had not been updated to address the issue identified at the previous inspection. The policy still referenced the 'Trust in Care, 2005' instead of the more recent HSE policy on the safeguarding of vulnerable adults in residential care (December 2014).

7. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

- Update the Centre's policy to reflect the more recent HSE policy on the safeguarding of vulnerable adults in residential care (December 2014).
- Provide staff with additional information, training and support in implementing the updated policy

Proposed Timescale: 31/03/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The risk management policy did not include or cross reference the measures and actions in place to control the unexplained absence of a resident.

8. Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

Complete the development and implementation of the Centre specific 'Risk Management Policy' to include the controls and procedures in place to minimise the risk and respond to the following potential incidents:

- The unexplained absence of a resident
- Accidental injury to residents, visitors & staff
- Aggression and violence
- Self- harm

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

The is failing to comply with a regulatory requirement in the following

respect:

The risk management policy did not include or cross reference the measures and actions in place to control accidental injury to residents, visitors or staff.

9. Action Required:

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Complete the development and implementation of the Centre specific 'Risk Management Policy' to include the controls and procedures in place to minimise the risk and respond to the following potential incidents:

- The unexplained absence of a resident
- Accidental injury to residents, visitors & staff
- Aggression and violence
- Self- harm

Proposed Timescale: 30/06/2016**Theme:**

Safe care and support

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

The risk management policy did not include or cross reference the measures and actions in place to control self-harm

10. Action Required:

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

Complete the development and implementation of the Centre specific 'Risk Management Policy' to include the controls and procedures in place to minimise the risk and respond to the following potential incidents:

- The unexplained absence of a resident
- Accidental injury to residents, visitors & staff
- Aggression and violence
- Self- harm

Proposed Timescale: 30/06/2016**Theme:**

Safe care and support

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

The centre has a risk register which included most but not all the environmental and clinical risks

11. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

Update the centre's risk register to include the following:

- All of the Centre's clinical and environmental risks
- The measures and controls in place to eliminate or mitigate all the identified risks

Proposed Timescale: Immediate – 31/01/2016

Proposed Timescale: 31/01/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

The quarterly notifications did not include information about the use of bedrails.

12. Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

Include data / information about any equipment / bedrails used in the delivery of care which may be deemed as a restraint

Proposed Timescale: 30/11/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

The activity of daily living assessments were tick boxes and did not support the

involvement of residents or families in their assessments.

Nursing assessments did not include the social, emotional and occupational needs of residents.

13. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

- Develop new and/ or redesign existing care plans to facilitate the following improvements:
 - Capturing additional resident-specific information
 - Assessing, planning and delivering the health, personal, social and occupational care needs of the Residents.

- Provide staff with additional education, training and support in adopting a more person centred approach in assessing, planning, delivering and evaluating the health, personal, social and occupational care needs of the Residents.

Proposed Timescale: On-going (Evaluation planned for 30.06.2016)

Proposed Timescale: 30/06/2016

Theme:

Effective care and support

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

Care plans were pre-printed and not person centred.

Care plans did not provide sufficient detail to guide the delivery of consistent care.

Care plans were not developed to meet the social and occupational needs of residents.

14. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

- Develop new and/ or redesign existing care plans to facilitate the following improvements:
 - Capturing additional resident-specific information
 - Assessing, planning and delivering the health, personal, social and occupational care

needs of the Residents.

- Provide staff with additional education, training and support in adopting a more person centred approach in assessing, planning, delivering and evaluating the health, personal, social and occupational care needs of the Residents.

Proposed Timescale: On-going (Evaluation planned for 30.06.2016)

Proposed Timescale: 30/06/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The centre had a clinical rather than a homely ambience.

Communal space was limited especially for residents on the first floor.

Free movement was restricted somewhat by locked internal doors.

Residents did not have free access to the external environment because the garden was not secured.

There was no suitable smoking area provided.

15. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Implement the existing 'Hollybrook Lodge Refurbishment Plan' submitted to the HIQA Office July 2015

Proposed Timescale: 31/01/2016

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

There was no record maintained of all complaints, including details of investigations and

outcomes of complaints including whether or not the complainant was satisfied.

16. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

Provide staff with additional information, training and support in the effective management of complaints in accordance with the Centre's updated Complaints Management Policy (see Outcome 5) including the timely and accurate completion of all pertinent records.

Proposed Timescale: 31/01/2016

Theme:

Person-centred care and support

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

Residents were not provided with advocacy services to assist them to understand the complaints procedure.

17. Action Required:

Under Regulation 34(1)(e) you are required to: Assist a complainant to understand the complaints procedure.

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

Provide Residents with the information, support and assistance required to understand and use the Centre's complaints procedure

Proposed Timescale: 31/03/2016

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

A resident who wished to return home did not have a plan detailing how this would be arranged.

Residents who were for resuscitation did not have an end of life care plan which detailed their wishes following their death.

18. Action Required:

Under Regulation 13(2) you are required to: Following the death of a resident make appropriate arrangements, in accordance with that resident's wishes in so far as they are known and are reasonably practical.

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

Develop individual end-of-life care plans in collaboration with each Resident and as appropriate the Resident's family / carers that includes arrangements for the Resident to return to their home where this is their expressed wish

Proposed Timescale: 29/02/2016

Outcome 15: Food and Nutrition**Theme:**

Person-centred care and support

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

Not all residents were offered menu choices at mealtimes.

19. Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

Ensure all staff are provided with information, training, support and supervision to ensure that all residents are offered appropriate menu choices at mealtimes

Proposed Timescale: 10/11/2015

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:

Facilities for occupation and recreation were inadequate.

20. Action Required:

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

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

- Appoint a full time Activity coordinator for the Centre.
- Furnish and equip the Activities Room with appropriate furnishings, décor and

equipment

- Continue to educate, train and support all staff in the implementation of the "Life story project" work with all residents including the development and implementation of meaningful individual activity

Proposed Timescale: 31/03/2016

Theme:

Person-centred care and support

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

Residents did not have opportunities to participate in activities in accordance with their interests and capacities.

Residents spent prolonged periods in bed.

21. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

- Appoint a full time Activity coordinator for the Centre.
- Furnish and equip the Activities Room with appropriate furnishings, décor and equipment
- Continue to educate, train and support all staff in the implementation of the "Life story project" work with all residents including the development and implementation of meaningful individual activity.

Proposed Timescale: 31/03/2016

Theme:

Person-centred care and support

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

There was no evidence that communication aids or specialist equipment was available to support the residents with communication problems.

There was no evidence that efforts had been made to replace the hearing aids that a resident had lost since she was admitted to the centre.

22. Action Required:

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

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

- Review, update and implement each Resident's communication care plan to include the assessment and provision of any specialist communication aids/ equipment identified
- Provide staff with additional information and training in the appropriate management of residents property including the actions to be taken in the event property is reported or identified as missing

Proposed Timescale: 10/11/2015

Theme:

Person-centred care and support

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

There were limited accessible facilities available where residents could meet with visitors in private outside of their bedroom.

23. Action Required:

Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

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

Continue to implement the Hollybrook Lodge Refurbishment Plan (submitted to HIQA July 2015) that provides for additional refurbished facilities for private visiting.

Proposed Timescale: 31/03/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

On the day of inspection there was a rich skill mix on duty, but inspectors found that staff were sometimes rushed and focused on the completion of care tasks rather than meeting the holistic needs of the individual residents.

24. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

- Continue to provide education, training and support for staff in developing a more

holistic approach in the delivery of person-centred care within the centre that better meets the health, personal, social and occupational needs of each resident. See also Action in Outcome 11.

- Continue to undertake regular assessment of staff numbers and skill mix to ensure the Centre can provide for the health, personal, social and occupational needs of each resident.

Proposed Timescale: Immediate and on-going

Proposed Timescale: 30/11/2015

Theme:

Workforce

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

Staff were not competent to assess or meet the social needs of residents.

25. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

- Continue to provide education, training and support for staff in developing a more holistic approach in the delivery of person-centred care within the centre that better meets the health, personal, social and occupational needs of each resident. See also Action in Outcome 11.
- Continue to undertake regular assessment of staff numbers and skill mix to ensure the Centre can provide for the health, personal, social and occupational needs of each resident.

Proposed Timescale: Immediate and on-going

Proposed Timescale: 30/11/2015