Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Hollybrook Lodge
Name of provider:	St James's Hospital
Address of centre:	St Michael's Estate, Bulfin Road, Inchicore, Dublin 8
Type of inspection:	Unannounced
Date of inspection:	23 November 2021
Centre ID:	OSV-0005053
Fieldwork ID:	MON-0034966

About the designated centre

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

Hollybrook Lodge provides residential care to 50 residents, with 46 resident beds and 4 respite beds. All residents and patients cared for in Hollybrook Lodge have access to specialist medical and nursing care, a wide range of support therapies including Physiotherapy, Clinical Nutrition, Medical Social Work, Speech & Language therapy and specialist aged-care services & treatments including Old Age Psychiatry, Bone Health, and Memory Clinic. Hollybrook is a secure, bright, purpose built two storey structure with stairs and a lift. There are two units, Robinson Unit on the ground floor, and the McAleese unit on the first floor. Each unit provides accommodation for 25 residents. There is an enclosed garden for resident's use adjacent to and behind the building. The family room is located on the first floor and there is an external designated smoking area for residents. The philosophy of the centre is to provide holistic person-centred care that promotes and safeguards the well-being and rights of each individual. The ethos of the centre is to create and maintain a suitable space for each resident ensuring individual privacy with space for their personal belongings and possessions in addition to facilitating recreational activities. The Hollybrook Lodge Residential Care Centre is managed by the Medicine for the Elderly Directorate of St James Hospital. The scope of the directorate services comprises acute in-patient, rehabilitation, out-patient, day care, transitional care, residential care and community outreach.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 23 November 2021	09:00hrs to 17:15hrs	Deirdre O'Hara	Lead
Tuesday 23 November 2021	09:00hrs to 17:15hrs	Jennifer Smyth	Support

What residents told us and what inspectors observed

From what residents told us and from what inspectors observed, residents were happy with the care they received within the centre. Inspectors observed many positive interactions between staff and residents. Overall, inspectors observed a relaxed environment in the centre throughout the inspection day.

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

Hollybrook Lodge is located over two floors, there is a range of single and four bedded rooms and all bedrooms had an en-suite shower facility. There was a range of communal rooms that were bright and decorated in a homely fashion. Seated areas were located along and at the end of corridor. There was open access to an enclosed garden with raised beds and seating which was available to residents and their visitors. Improvement was needed in the enclosed garden to ensure that it was tidy. It was seen to be littered and open bags of sand spilled out onto one foot path. Two seating benches were broken and not safe for use.

The inspectors spoke directly with residents and the feedback from residents was that the staff who delivered their care were kind and attentive. Inspectors observed that staff greeted residents by name and residents were seen to enjoy the company of staff. Staff were observed to speak with residents kindly and respectfully, and to interact with them in a friendly way.

Inspectors observed that the care staff knew the residents well and were aware of their individual needs and preferences. Staff spoken with were knowledgeable of their role and reported that they were well supervised and supported. One resident stated "Staff are nice, they look after me well". Others said that staff were caring and kind to them.

Where residents had communication needs, staff interacted with them in an unhurried manner and staff used active listening skills to promote good communication. Staff were also overheard discussing topics of personal interest with residents. Examples of this were sport on the TV and activities they knew they enjoyed.

During the course of the inspection, inspectors found that staff maintained residents privacy and dignity in their bedrooms. They were protected by the use of curtains and staff knocking on doors and seeking permission before entering resident rooms or closing or leaving bedroom doors open if residents requested this. However residents were required to wear bands on their wrists which was an infringement on their privacy and right to make choices.

Residents were seen to choose where to take their meals, some chose to dine in the communal rooms and others chose to take their meals in their bedrooms. Inspectors observed the lunch time meal and found a mixed experience on each unit. There was a relaxed atmosphere on one unit, while on the other unit there were high levels of noise coming from catering trollies and the TV.

Inspectors saw that there was plenty of choice available on the food menus. Specialised textured diets such as pureed food was presented in a way that each food group was not identifiable and was blended together. A small number of staff were seen to assist residents while they stood over them. This did not lend itself to a positive dining experience for the residents concerned. Other residents were assisted in an unobtrusive and encouraging manner.

There was mixed feedback from residents regarding the food that was on offer. One said they did not like the food and another said the meat was tough. Two other residents said they liked the food. Inspectors saw that some plates after residents had finished their meal were quite full.

Inspectors saw that residents had access to a range of meaningful activities and social opportunities in the centre. The activities were specific to the needs of residents. There was a weekly timetable of activities available to residents in the centre and on the day of the inspection activity staff held a group baking session. A fresh baking aroma could be found within the centre in the afternoon.

A resident survey was carried out in July 2021, with a return of 29 surveys. Highest positive feedback was in satisfaction with residents rights which scored 85%. The lowest satisfaction was with the provision of activities within the centre, scoring 62.1%. Residents also had access to an advocacy service. Residents were not regularly consulted about the running of the centre by means of residents meetings. The last resident meeting was held on the 1 March 2021, the next scheduled resident meeting was planned for the 25 November 2021.

Residents said they found the centre comfortable, efforts had been made to promote a more sociable seating arrangement in the communal day rooms since the last inspection being mindful of social distancing requirements. While visiting was restricted in the centre, which was imposed by the provider, there was sufficient space for residents to meet visitors in private within the designated centre. On the day of inspection, inspectors spoke to a visitor who was unhappy with the visiting restrictions, they stated that there was no flexibility, the time of the visiting is given, there is no choice and that the visits are limited to four weekly visits per resident. Visits were accommodated in the family room for those residents who resided in the four bedded rooms.

Inspectors also spoke with residents' family members, who spoke positively about the service, one visitor said that "the staff were really good." They indicated that they felt welcomed by the staff when they visited. They said that they were kept updated regarding their loved ones condition and that they were well cared for. They mentioned that if their family member's condition changed, they were promptly seen by the GP or medical specialists.

Residents said they knew who they could go to if they were concerned or dissatisfied with any aspect of living in the centre. Residents told inspectors that they felt safe in the centre and that staff were caring and kind to them.

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

Capacity and capability

The centre was well managed by a management team who were focused on improving resident's wellbeing. Residents received good care and support from staff. The layout of the building provided them with plenty of space and access to the outside and residents could make choices on how they spent their day. There were effective management structures in place that ensured care was provided in a safe and sustainable way. However, improvement was required with regard to information submitted in notifications of incidences to the regulator, governance and management, statement of purpose, written policies and procedures, complaints and records.

This was an unannounced inspection of Hollybrook Lodge to review on-going compliance with the regulations. The centre is part of St. James's Hospital group, and had its own internal governance structures, as well as clearly defined links with the managers of St James's hospital. The well defined internal governance structure was an improvement since the last inspection. The Chief Executive Officer (CEO) and senior management team are responsible for the operational management of the services provided by Hollybrook Lodge.

The person in charge was new to the position and was suitably qualified to carry out their role. They reported to the CEO and the assistant director of nursing who were based in St. James's Hospital. The person in charge reported that they were supported by this team who were readily available to them.

There was an appropriate allocation of nursing, carers and ancillary staff available to meet the assessed needs of residents. The inspector observed that residents had their personal care requests attended to promptly during the inspection. Rosters showed that there were four nurses on duty in the centre at all times.

Staff were supervised in their roles by the person in charge and four nurse managers who provided oversight to care and support staff in their work. The cleaning supervisor provided supervision to household staff and the head chef oversaw catering staff. The inspector reviewed examples of probation and competence reviews by management to highlight areas of good practice, and to support staff with career development objectives and areas in need of improvement.

The person in charge and four nurse managers supervised staff to ensure a high

standard of care was given to residents. All staff with the exception of four, had received mandatory fire training. These four staff were booked into training scheduled the day following this inspection. Staff had received training to ensure they remained competent in their role, this included training in cardio-pulmonary resuscitation, medication and management of actual or potential aggression. However, records showed that infection control training had not been carried out since 2020.

The provider had not updated the statement of purpose since October 2020, to ensure that all relevant stakeholders were reflected and aligned with the services provided and the current conditions of registration.

The person in charge had started working in the centre two months before the inspection took place. They were recommencing meetings in the centre to ensure that there was adequate senior management monitoring and oversight of the care being delivered in the centre. For example while the last resident meeting was in March, one was scheduled to take place the day following inspection. They had also commenced a two monthly quality review group meetings where the CEO, the director and assistant director of nursing and other management staff attended. The oversight of clinical and non-clinical data was discussed at this forum. Quality improvements were seen to be discussed in records, such as the development of pictorial menus and the recommencement of the volunteer program, in order to enhance the lived experience of residents.

The infection control committee met in September to review findings and develop action plans to address gaps found during environmental audits in the centre.

The number of suspected or confirmed cases of COVID-19 had remained small since the last inspection. Improvement was required to ensure that all incidences of suspected or confirmed cases of COVID-19 infection among residents and/or staff in the centre are reported to the regulator.

The complaints procedure was on display in the designated centre and the complaints policy was up-to-date. Residents and staff, who spoke with inspectors knew how to make a complaint. However, improvement was needed to ensure that the outcome and satisfaction levels of the complainant was recorded and that verbal complaints were dealt with in alignment with the centres policy. There was one open written complaint where the provider was to meet with the complainant to discuss the investigation findings.

The annual review for 2020 did not show that residents or families were consulted in its development and a copy of the review was not available in the centre for residents and families. However, the person in charge had arranged for the distribution of a survey to residents and family members. This was due to be analysed in January of 2022 and the person in charge told inspectors that this would be used to inform the annual review for 2021 and influence any quality initiatives to improve life for residents.

Records and documentation required by Schedule 2, 3 and 4 of the regulations were made available on the inspection day. However records with regard to Schedule 3:

Resident records, were not securely stored. In addition, the records required by Schedule 2 for staff were not complete, as required by Regulation 21: Records.

Significant work had been completed to update policies in the centre to ensure that they were centre specific and aligned with the services provided. There were two policies that were out of date and were in the process of being completed. The visiting policy needed to be updated as it did not reflect practice on the inspection day. The person in charge informed inspectors that they intended to form a specific policy committee for the centre to review and update policies in a timely manner, as required by regulation.

Regulation 15: Staffing

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

Judgment: Compliant

Regulation 16: Training and staff development

During 2020, 23 staff had attended infection control training, 11 staff have not completed training in the last two years. This is not in accordance with the designated centre's infection control policy which states that all staff members will receive infection control training every two years.

Judgment: Not compliant

Regulation 21: Records

Staff records as required by Schedule 2 of the regulations were kept in the designated centre, however evidence of the addresses of staff was not present on their file.

While resident records were readily accessible, they were not stored in a locked cabinet or in a locked room in the designated centre.Therefore residents' confidentiality was comprised.

Judgment: Not compliant

Regulation 23: Governance and management

The following improvement was required in order for the centre to come into compliance with this regulation:

Last year's annual review for 2020 did not show how residents and their families were consulted in the preparation of the annual review.
This annual review was not available for the residents or families to view.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had not been reviewed within the last year.

This document did not contain the information required by Schedule 1: Information to be included in the statement of purpose. It had not been updated to include the conditions that the centre was registered under and the person in charge detailed in this document had left the service.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not given the Chief Inspector notice in writing of one suspected and one confirmed case of COVID-19 in the centre within three working days of its occurrence.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider maintained a log of written complaints received which outlined the issues raised, however the outcomes, learning and complainant satisfaction from issues raised were not recorded for one written compliant.

In one of three verbal complaints during 2020, there was no satisfaction or outcome recorded. There was no records of verbal complaints for 2021 to show that the provider had responded appropriately or had put in place any improvement measures if required. Complaints at the last residents meeting such as missing laundry and cold food had not been investigated or recorded as being followed up by the person in charge.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Two policies were overdue review and were in draft format and remained held up at the St. James's Hospital policy committee. The overdue policies were the communication and advocacy policy and the medical emergency policy. This meant they were not readily available to guide staff.

Judgment: Substantially compliant

Quality and safety

Overall residents wellbeing and welfare was maintained by a good standard of evidence-based care and support. While many residents were content living in the centre and said they felt safe, improvement was required in infection control and premises, resident rights and visits.

Residents had access to GP and to geriatric services from St. James's Hospital. There was evidence of access to allied health and social care professionals to assess, recommend supports and meet resident care needs. Recommendations made by specialists were undated to reflect the current needs of residents, and guided staff in care delivery.

Residents care plans and daily notes were recorded in a paper format, the person in charge informed inspectors that the provider will be introducing an electronic system to record nursing notes next year. Inspectors found that care plans were based on a comprehensive assessment of resident need, with a variety of clinical tools used to assess and monitor resident's needs and associated risks.

Care plans which guided staff caring for residents with responsive behaviours were found to promote the rights of residents with least restrictive measures identified and used to promote resident autonomy and safety. Care plans reviewed indicated that where residents were unable to engage in this process the views of their families and loved ones were sought and incorporated into these plans. However it was noted no risk assessment was carried out for one resident who had responsive

behaviour and required close supervision.

There were adequate opportunities for residents to participate in activities according to their wishes and capacities. An activity therapist was employed in the centre Monday to Friday who provided recreational activities on a one-to-one basis or group therapies. There were weekly reminiscence classes held by the occupational therapist, a falls prevention programme by the physiotherapist and a sensory activity group had recently started.

The residents also had access to an advocacy service. Inspectors observed that residents wore hospital type identification bracelets. Inspectors were informed that these were used in the administration of residents medication, to highlight residents who were at high risk of falls and use them for bar coding machines when monitoring blood sugars. This was intrusion on residents rights to privacy and infringed on their dignity.

Visiting was arranged by a booking system, which limited visits to six family visits for the entire centre, every hour. Each resident was limited to four visits every week. The time of these visits were allocated by the provider and feedback from families relayed that this was not a flexible arrangement and often did not suit. Practice did not reflect the designated centre's own visiting policy which stated "that visits should not be scheduled in advance with family." or the latest guidance from the Health Protection Surveillance Centre. These findings impacted resident rights to maintain meaningful relationships with people who are important to them.

There were low numbers of positive cases of COVID-19 since the last inspection. Infection prevention and control strategies had been implemented to effectively manage or prevent infection in the centre. These included implementation of standard and transmission-based precautions for residents, with ample supplies of PPE. However, refresher training was required to ensure hand hygiene was effective for six staff.

A successful seasonal influenza and COVID-19 booster vaccination program had taken place in the centre, with vaccines available to residents and staff. While there was good monitoring for signs and symptoms of COVID-19 infection for residents and visitors, there were gaps seen in monitoring records for staff.

The physical environment was generally well-maintained and ventilated. Corridors were free of clutter, bright and clean. Emergency magnetic release catches had been installed to all doors since the last inspection, this was to ensure that doors would automatically close in the event of a fire. However, improvement was required with regard to the general upkeep of the courtyard to ensure that it was clean and well maintained. There was inappropriate storage of equipment in assisted bathrooms. This practice could lead to cross contamination and could impact on the rights of residents' should they wish to use the bathroom. One medication fridge was not maintained at the correct temperature and had not been reported as defective by staff. This could impact the quality and safety of residents medications stored in this fridge.

The risk management policy met the requirements of the regulation. There were

associated risk policies that addressed specific issues such as the unexplained absence of a resident, self-harm, aggression and violence, safeguarding and the prevention of abuse. There was a risk register in the centre which covered a range of risks and appropriate controls for these risks. There was an emergency plan available that was updated recently to include a contingency plan in the event of a COVID-19 outbreak.

Regulation 11: Visits

Restricted choices on visiting times was not in alignment to the latest guidance from the Health Protection Surveillance Centre. Practice did not reflect the designated centre's own visiting policy. No risk assessment was available to justify why visiting was restricted in this way. For example, staff allocated visiting times to visitors and residents were limited to four visits a week.

Judgment: Not compliant

Regulation 17: Premises

Improvements were required in the following areas which impacted on cleanliness, safety and rights of residents:

- Medication fridge on one unit was not maintained at the recommended temperature and had not been reported to the maintenance team.
- Inappropriate storage of wheelchairs in two assisted bathrooms.
- There was assistive walking equipment stored in a vacant bathroom.
- The external courtyard and smoking area were not clean. They were littered with food packaging and the contents of grit bags had spilled out onto one foot path. Ash trays in the smoking area were full.
- Two seating benches in the courtyard were broken and not fit for use.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy in place which included a process for hazard identification and assessment of risks throughout the designated centre. Staff were aware of risks that could impact on resident safety and there was a good awareness among staff with regard to clinical and operational risks.

Judgment: Compliant

Regulation 27: Infection control

Issues important to good infection prevention and control practices which required improvement:

- There were gaps in COVID-19 monitoring records for staff in one of the units.
- Three staff were seen to wear watches and three staff wore a stoned rings.
- One intravenous tray was seen to be unclean with an old sticker remaining which would not facilitate adequate cleaning.
- Continence wear was stored in open packages on trollies stored in assisted bathroom which could lead to cross infection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Fourteen care plans were reviewed on the day of inspection, they were found to be person centred reflecting the individual resident. Residents had a comprehensive assessment of their care needs prior to admission and care plans were prepared within 48 hours of admission. Consultation in the preparation and/or review of care plans was seen to be evident with residents and their families, if appropriate.

Judgment: Compliant

Regulation 6: Health care

There was a good standard of health care, with residents having regular access to GP services. Access to allied health and specialist medical services, where required, was facilitated in a timely manner.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The care plans reviewed in respect of responsive behaviour were reflective of good practice. An enhanced care observation record which included triggers was

maintained on residents identified with challenging behaviours.

Judgment: Compliant

Regulation 8: Protection

Records showed that appropriate measures were taken to protect residents. In two safeguarding investigations examined, the correct actions were taken, open disclosure and referral to appropriate agencies. The Safeguarding team had reviewed and investigated both incidents and had made recommendations to prevent future re-occurrence. The designated centre had an up to date safeguarding policy and staff had good knowledge in relation to recognition of abuse and appropriate actions required by them.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were required to wear identification bands containing personal information which was an infringement on their right to privacy. This was an institutionalised hospital practice in their home. Bands highlighted residents who were at risk of falls which also infringed on their dignity, as visitors and other residents could see the labels. Residents have a right to make choices about how information about them is shared.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Hollybrook Lodge OSV-0005053

Inspection ID: MON-0034966

Date of inspection: 23/11/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staffs informed that Infection prevention & control training is now mandatory and needs to be updated every 2 years. Local records amended to reflect same. • All staffs within Hollybrook lodge will complete the HSE land infection control online training by end of January 2022	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • Lockable chart trolleys are ordered for the safe and confidential storage of resident files within the CNM office on each unit. • All nursing and medical staffs informed regards the need to keep files stored securely and confidentially when not in use • All staffs informed of the need to provide a copy of their proof of address and photo ID for their personnel records.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Resident association and nominated person's association group forums, to be used to discuss annual reviews and outcomes of HIQA inspections with both the residents and their nominated persons.
• Booklet display holder to be placed in the front foyer of the centre. This will hold the Annual review report and the most recent HIQA inspection report which will be accessible to both the residents and the public for their perusal.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Statement of purpose updated with registration details and Person in charge details

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All staffs and residents whom are suspected/confirmed cases of COVID 19 to be notified to HIQA within 3 working days. PICC post formal fitness interview to be given access to the postal for submission of notifications.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Local education and training session by the PIC with local managers to embed the local complaint's log process.
• The PIC to complete an audit of the logs on a monthly basis to ensure the process is adhered to and address accordingly if needs be.

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • Local development policy and review group to be established to ensure deadline dates on policies are updated, etc. • First meet of this group are scheduled by end of January 2022.	
Regulation 11: Visits	Not Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: • Liaise with our SJH Health and Safety officer to ensure an appropriate general visiting risk assessment in situ for Hollybrook Lodge. • Continue to complete individual risk assessment forms for each visitor on arrival to the lodge and log this assessment for recording purposes • Visiting processes remain flexible with different areas within the lodge accessible for residents, staffs and visitors in order to facilitate safe visiting- visiting pod/ individual rooms, family room, outdoor gazebo etc. Visiting remains organized by a scheduled process in order to continue to safeguard our residents, staffs and visitors.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • General support services whom maintain the outdoor garden spaces have now been increased to twice weekly	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection	

control:
COVID 19 local monitoring records addressed on the day of inspection.
• Local managers / Nurse in charge reeducated regards the importance of maintaining adequate COVID 19 local records on the commencement of each shift
• Action plan developed to address issues with staffs' noncompliance to Hand hygiene standards
• Twice daily checks of medication trays by the nurse in charge introduced to ensure they are clean and ready for use in the clinic room.
• Staffs re- educated regards the process of storing Continence wear by residents' bedside as appropriate.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: 'Residents have the right to decide if they do not want to wear ID bands. Staff to discuss with each resident or their nominated contact person as appropriate whether or not they wish to continue to wear same. Different processes to be explored in order to ensure residents are easily identifiable without the use of ID bands. Relevant policies and documentation within the centre to be amended to reflect these changes.
All new residents will not be offered ID bands on admission to Hollybrook Lodge. A resident photo profile will be updated on admission, once every 6 months and as required for identifying purposes. The photo profile will be secured in lockable trolleys in CNM's office.'

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(1)	The registered provider shall make arrangements for a resident to receive visitors.	Not Compliant	Orange	28/01/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	28/01/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	26/11/2021
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	30/01/2022
Regulation 23(e)	The registered provider shall ensure that the	Not Compliant	Orange	28/02/2022

	review referred to in subparagraph (d) is prepared in consultation with residents and their families.			
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	30/01/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	04/12/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Not Compliant	Orange	30/01/2022
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	11/01/2022
Regulation 31(1)	Where an incident	Substantially	Yellow	29/12/2021

	set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Compliant		
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	30/12/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	30/12/2021
Regulation 34(1)(g)	The registered provider shall provide an	Not Compliant	Orange	30/12/2021

	accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.			
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	30/12/2021
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Yellow	30/12/2021
Regulation 04(3)	The registered provider shall	Substantially Compliant	Yellow	25/03/2022

	review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	25/03/2022