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:	Clearbrook Nursing Home
Name of provider:	Greenmast Limited
Address of centre:	Heathfield View, Cappagh Road, Finglas West, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	08 December 2021
Centre ID:	OSV-0005590
Fieldwork ID:	MON-0034887

About the designated centre

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

Clearbrook Nursing Home is a designated centre delivering care to male and female residents, located in a north Dublin city suburb. The premises comprises of a two-storey, purpose-built building with 90 single en-suite bedrooms. The centre consists of four separate units with central communal spaces including dining areas, sitting rooms and activity rooms. Full-time long and short-term care is provided for older people, people living with dementia, and people with physical and sensory disabilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	73

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 8 December 2021	08:15hrs to 18:30hrs	Margaret Keaveney	Lead
Wednesday 8 December 2021	08:15hrs to 18:30hrs	Niamh Moore	Support
Wednesday 8 December 2021	08:15hrs to 18:30hrs	Siobhan Nunn	Support

What residents told us and what inspectors observed

Overall, residents living in Clearbrook were supported to enjoy a good quality of life. Inspectors spoke with a number of residents, and approximately seven in detail to identify their experiences of living in the centre. Residents spoken with were complimentary of the service provided, in particular the food and the kindness of staff. Visitors spoken with were also complimentary about the staff and the care provided to residents. Some visitors voiced that the change in management team, over the summer months of 2021, had been positive for residents and in particular noted the improvements in staffing levels.

On arrival inspectors were met by a member of the senior management team who guided them through the necessary COVID-19 infection prevention and control measures. These processes were included a signing-in process, hand hygiene, the wearing of face masks, and checking for signs of COVID-19.

Throughout the day, there was a calm and relaxed atmosphere in most areas of the centre. Inspectors observed that residents appeared comfortable and content, and were well-dressed. Residents were facilitated to relax and socialise throughout the centre and it was evident that they were free to choose how they spent their day. On entry to the centre, inspectors met one resident enjoying their breakfast of tea, toast and Christmas cake. Inspectors also overheard residents unexpectedly changing their mind about their breakfast options and staff respected these requests politely and without fuss. Throughout the day, it was apparent to inspectors that residents enjoyed each other's company. Residents were observed to spend time socialising together outside of organised activities and to chat cheerfully in small groups in communal areas. Inspectors also saw that residents were supported to maintain their interests. For example a schedule of upcoming soccer matches was advertised in communal areas.

The centre was laid out into four units over two floors, which were accessible by lifts and stairs. There were 90 bedrooms, each with their own en-suite bathroom. Inspectors saw that residents' rooms were personalised with family photographs, bed throws and other personal memorabilia. Many bedrooms had also been adorned, by residents and their families, with Christmas lights and decorations. There was adequate storage space in residents' bedrooms for their clothes and personal belongings.

There were a number of comfortably furnished and bright communal areas on each floor for residents to socialise, relax and dine in. These areas had been tastefully decorated for the upcoming Christmas festivities. However, inspectors observed that residents had restricted movement in one dining room over the lunchtime meal, due to the number and positioning of wheelchairs in use. Throughout the centre, there was good signposting to communal areas to assist residents with finding their way. The provider had undertaken to redecorate some areas of the centre and repainting

of handrails in colours particular to each unit was underway to help orient residents.

There was a large, well maintained enclosed garden that was easily accessible from the communal rooms on the ground floor. It was wheelchair-friendly with wide paths and suitable garden furniture for residents to sit and enjoy in fine weather. There was also a boules green for the resident use, which was well kept, and a well-constructed smoking shelter. Inspectors saw that residents had enjoyed garden parties with staff over the past summer.

From discussions with the management team, it was apparent that they placed great significance on providing nutritious and wholesome food to residents and that they recognised meals to be a central part of the residents' day. The provider had recently appointed a new chef and catering team who actively engaged with residents to obtain their input into menus. Residents were offered a choice regarding the food they ate, and written and pictorial daily menus were clear and prominently displayed. Residents could choose when and where to take their meals, and meals were seen to be well presented and appealing. A variety of nutritious snacks were also available to residents throughout the day.

The registered provider employed two activity coordinators who worked Monday to Sunday. Inspectors observed group activities to take place on the day of the inspection, such as a sensory group and carol practice and dancing to Christmas songs. Activities staff had also planned arts and crafts activities which focused on the upcoming Christmas season. Inspectors found that staff knew the residents' well and were seen to have a good rapport, encouraging them to participate. Inspectors also observed quieter one-to-one activities such as colouring to take place. Inspectors were told that mass is live streamed for residents each Sunday. Residents were supported to maintain their cognitive health through a 'Don't be bored' board hanging in one communal area that offered thinking activities to residents.

There were posters displayed within the centre to remind residents of upcoming events such as a planned residents meeting and Christmas jumper event occurring the week of the inspection. Inspectors reviewed minutes from previous residents' meetings and found that resident's feedback was being used to improve the service. For example, residents requested a clock within the sitting room downstairs and upstairs which was seen in both rooms. In addition, residents requested the return of live music and there was live music planned as part of the Christmas party for the week following the inspection.

Inspectors observed multiple occasions where some staff were repeatedly wearing their face mask inappropriately. In addition, inspectors observed some staff to have poor hand hygiene during times when assisting residents' including during a supervised medication round.

Residents told inspectors that they felt comfortable to raise concerns or complaints with staff. One resident told inspectors that they raised a complaint previously about the size of the outside smoking area and described the space as limited with their mobility aid. This resident told inspectors that as a result a new area was built which

was much more satisfactory.

Inspectors observed occasions during the inspection where residents from the first floor requested or required staff assistance and there was insufficient staff available to meet their needs. During the administering of medication to residents at 0900, the nurse on this floor was interrupted three times, as three other residents called for assistance and requested items such as a cup of tea and breakfast. Inspectors observed the nurse leaving the medication administering procedure to seek another staff member. Also during the 1500 medicine round, this same staff nurse had to intervene and assist with an occasion of responsive behaviour between two residents. This delayed the medicine round but also created a risk to safe medicine administration.

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

This was an unannounced inspection of Clearbrook Nursing Home to follow up on solicited and unsolicited information submitted to the Chief Inspector of Social Services. Residents received good care and support from staff, had access to recreational opportunities and could make choices on how they spent their day. However, governance and management processes were required to improve, as evidenced by the inspection findings relating to staffing allocations, training, care planning, medication management and infection control practices.

The centre is owned and operated by Greenmast Limited, who is the registered provider. There were well-defined management structures in the centre, and the roles and responsibilities of personnel were clear. The person in charge had started in their role in May 2021 and the General Manger in August 2021. The General Manager and Registered Provider Representative worked in the centre daily to oversee operations and to support the person in charge and staff. The person in charge was also supported by an assistant director of nursing, two clinical nurse managers, a team leader and team of healthcare assistants, a catering team and a household team. Staff spoken with were clear about who they reported to.

The management team had sought external assistance in identifying gaps in the management systems and in ensuring that the care, health and social needs of residents were being safely met within the centre. The team had subsequently developed, and partially completed, a comprehensive action plan to address the gaps identified. The management team held a suite of regular meetings to discuss, amongst other issues, staffing and training, resident care, health and safety issues, incidents involving residents and risk management. While there were effective management systems in this centre ensuring that residents had access to good health and social care, inspectors were not assured that the provider had adequate

systems in place to ensure that safe clinical care was being delivered to residents. This will be further discussed under regulations 5, 27 and 29. Although there were an adequate number of staff in the centre on the day of the inspection, a review of staff allocations, in response to unexpected staff leave, was required to ensure that nursing staff were able to complete safe medication rounds. This is further discussed under regulation 29.

The provider had completed an annual review report for 2020, which included evidence that residents and their families had been consulted on the quality and safety of care provided in the centre.

The centre was adequately resourced to meet the health and social care needs of the residents with a minimum of two nursing staff working in the centre at all times. A housekeeping supervisor had recently started in the centre but due to shortages in cleaning staff resources was unable to assume her supervisory duties on the day of the inspection. This impacted on infection prevention and control practices as discussed under regulation 27 below. An additional cleaner was due to start in the centre the week following the inspection.

Inspectors saw that there were significant gaps in mandatory training for staff, such as fire safety, infection prevention and control and manual handling. The management team had identified these gaps and developed a training plan for the four months following the inspection to ensure that staff received the necessary training to ensure they could provide positive outcomes for residents in their care. Safeguarding of vulnerable adults training was scheduled to take place on the day of the inspection and fire safety training was scheduled to take place two weeks following the inspection. An induction programme for new staff and annual appraisals programme had been developed by the management team.

While inspectors were told a medication review had been completed by the general practitioner (GP) the week of the inspection, residents records had not been updated. Inspectors viewed a letter from the GP confirming that the medication reviews had been completed. The records of four staff members were reviewed and found to contain the documents as required by the regulations, including An Garda Síochána vetting disclosures, references and verification of the current registration of professional staff.

Inspectors reviewed the 2021 complaints log which evidenced that complaints received had been well investigated and responded to. The documentation showed that the management team had engaged with the complainant, often through in person meetings, to ensure that all reasonable measures were taken to reach a satisfactory outcome. Inspectors observed that some complaints had led to improvements in the service provided to residents, such as the appointment of a new chef who consulted regularly with residents on devising new menus to meet their preferences.

Regulation 15: Staffing

The registered provider had provided an appropriate number and skill mix of staff to meet the assessed needs of residents, and with regard to the size and layout of the centre.

There were a minimum of two registered nurses on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that many staff did not have up-to-date mandatory training in fire safety, infection prevention and control practices, manual handling and the safeguarding of residents from abuse. Such training is required to ensure that staff provide safe and effective care to all residents.

The registered provider had plans in place to address the gaps within two weeks of the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not have robust management systems in place to ensure that the service provided to residents was safe and effective. For example:

- Significant gaps in care planning were identified. For example, a number of care plans did not have the correct review dates recorded, which could result in staff not having the most up-to-date guidance on caring for residents.
- Action was needed in relation to infection prevention and control documentation and practices to ensure that they delivered the best outcomes for residents.
- Greater oversight of medication management was required to ensure that staff followed professional guidance and codes of practice relating to the storage, administration and disposal of medicines.
- Monitoring systems were required to ensure that restraint was used in accordance with national policies, particularly relating to the documentation of consent when restraint is being used.
- Contingency plans for sudden staff shortages required review. On the day of the inspection staffing allocations impacted on managing residents' responsive behaviours, safe medication administration and infection control practices.

These findings are further discussed within this report.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints procedure was prominently displayed in the foyer of the centre. The Director of Nursing was the nominated person to deal with complaints and there was a nominated person to oversee the management of complaints.

There was evidence of effective management of the complaints received with the satisfaction of the complainant recorded.

Judgment: Compliant

Quality and safety

Overall, residents were supported and encouraged to have a good and active quality of life which was respectful of their wishes and preferences. The findings of this inspection showed that residents' needs were being met through good access to health care services, opportunities for social engagement and through occasions to voice their opinion on the service. However, the inspector identified that some improvements were required in care planning, managing behaviours that challenge, infection control and medication management.

The provider had recently engaged the services of a new General Practitioner (GP) who visited the centre once a week or as required. Nursing staff generated a weekly record of residents who needed to be seen by the GP each week. Residents also had access to an out of hours medical service. Residents' health care needs were also supported by a physiotherapist who visited the centre twice per week, and by a tissue viability nurse and a dietitian when required. Inspectors saw documentary evidence that residents preferences for health care were clearly recorded. A multi-disciplinary team meet quarterly to review residents' needs.

From the sample of resident files reviewed, inspectors saw that on occasions where residents displayed behaviours that challenge, there were clear records on the triggers and management of such behaviours. There was also documented evidence that the management team regularly monitored the use of physical and chemical restraint within the centre. However, in the sample of resident records reviewed, inspectors saw that for some residents with a restraint in place there were incomplete care planning records in place to evidence their use and guide and support staff. Inspectors also saw that there was no documented evidence that

explicit consent on the use of restraint had been obtained.

Residents were assessed prior to admission to the designated centre and care plans were developed within 24 hours of admission to the designated centre. Following a review of the records of six residents inspectors found that the dates for the reviews of care plans were not aligned with changes that had been made to care plans. This resulted in confusion about review dates and resulted in some care plans not being reviewed on time. Inspectors were told that the electronic recording system had been updated and that staff were in the process of creating individual care plans from previous composite care plans. For example care plans for mobility, food and nutrition and communication which were previously contained in a composite plans. On the day of inspection only some records had been changed to the new system. This resulted in two different systems operating at the same time.

The centre had a clear policy in place for the prevention of and responding to allegations of abuse. Although for many staff their training on safeguarding residents from abuse was out of date, staff who spoke with inspectors were clear about their responsibility to keep residents safe and knew how to report any concerns or allegations in relation to abuse. The provider had notified the Chief Inspector of Social Services of a number concerns of alleged or suspected abuse within the centre and inspectors saw that all had been investigated thoroughly and measures put in pace to mitigate against them recurring. There were appropriate processes to manage residents' pensions. Inspectors also saw evidence that residents' finances were managed in line with best practice and that residents were facilitated to easily access their money whenever they wished. Residents also had access to advocacy services.

Inspectors found that there were many opportunities for residents to participate in activities in accordance with their interests and capacities. There was an activity schedule displayed within communal areas which had activities planned seven days per week. Activities planned for the week of inspection were festively themed with planned activities such as Christmas jumper's day and a Christmas party. There was an activity board which had copies available for residents' use such as crosswords, word searches and colouring templates.

Residents were able to choose when they got up and when they went to bed and how they spent their time. Many residents were seen to mobilise around the centre and to spend time in communal areas, while others chose to remain in their bedrooms. Inspectors observed staff spending time with residents in their bedrooms.

There was good access to visiting arrangements within the centre. Inspectors observed that residents had access to the guidance on visiting from the Health Prevention Surveillance Centre on notice boards within the centre. Inspectors spoke with five visitors, all of whom were complimentary of the visiting arrangements and of the care their loved one received within the centre.

The provider had an up-to-date risk management policy in place which outlined the arrangements to monitor and manage risks within the centre. The management

team had compiled a comprehensive list of health and safety, operational and COVID-19 risks which were logged in separate risk registers. Identified risks were controlled through the risk assessment process where control measures were put in place to reduce the risks. Each risk had an appropriate control, person responsible and risk rating applied but did not have a review date assigned to ensure that effective controls remained in place. However, inspectors saw that identified risks were regularly discussed at management meetings.

While the centre was clean, inspectors found that on the day of the inspection, there was not sufficient oversight of infection control measures and improvements were required to ensure that good practice was implemented in a consistent manner. Inspectors were informed that the centre had employed a cleaning supervisor, however the role had not been filled as the post holder had to cover a vacant cleaning post. Inspectors were told that a review of cleaning schedules and practices was due to be completed when the role was commenced.

Inspectors observed some good practices of medicine management within the centre. Medicines were stored securely within locked cupboards with the nurse retaining the key at all times, however action was required to ensure the temperature of the medicine fridge was checked regularly. Residents' prescriptions identified which medicines were to be crushed and was signed off by the prescribing doctor. There were policies available for medicine management, however, inspectors found evidence where the policies were not followed on the day of the inspection. For example, the policy referred to signing and dating medication including the dates and times administered, however these process were automated as a result of the new electronic system. Inspectors found that although policies had been reviewed recently, the Administration and Review of Medications policy did not refer to the medication administration record (MAR) system being electronic. Inspectors also found areas of practice such as safe administration which required improvement which will be further discussed under Regulation 29: Medicines and Pharmaceutical Services.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Inspectors observed residents receiving visitors with the necessary infection prevention and control measures completed throughout the day. Visits were seen to take place in residents' bedrooms and also in communal areas.

There was a risk assessment on visiting in place which was in line with visiting arrangements seen on the day of the inspection. Residents spoken with confirmed that they were happy with the visiting arrangements in place.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place to guide and inform staff in the centre. There were also controls and measures in place for the five specified risks as required by Regulation 26. The provider had compiled risk registers covering care and service risks, health and safety risks, corporate risks and COVID-19 risks.

There was a plan in place to respond to major emergencies.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required to ensure the registered provider was in compliance with the National Standards for Infection Prevention and Control in Community Services 2018. For example, there were gaps in the monitoring records of staff for signs and symptoms of COVID-19. Furthermore:

- PPE and hand hygiene practices were not in line with national guidance:
    - Three staff were seen to wear their face masks inappropriately, which may result in the spread of infection. Inspectors highlighted this on three occasions during the inspection
    - Four staff were seen to wear watches and stoned rings,which prevents adequate hand washing
    - Inspectors observed a number of occasions of poor hand hygiene practices on the day of the inspection, including occasions when assisting residents with personal care, medicines and during a meal-time
    - Clinical hand-wash basins did not meet the national standards.
- Cleaning schedules and procedures required review:
    - There were no current cleaning schedules in practice on the day of the inspection, therefore inspectors could not verify when areas were last cleaned
    - Some resident equipment such as hoists and urinals were visibly dirty.
    - There was visible dirt and debris seen on the storage racks of bedpans and urinals in two sluice rooms
    - A medicine trolley was visibly dirty
    - There was no cleaning schedule for the medicines fridge

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found that action was required by the person in charge to ensure they had sufficient oversight of the following areas of medicine management within the centre.

- To ensure that all medicinal products dispensed or supplied to a resident were stored securely. For example:
    - Inspectors viewed the records of two fridges used to store medicines and found there were gaps in the recording of temperatures for both fridges. This was also a finding of an internal medication audit completed on 01 December 2021
    - Inspectors observed some opened medicines in the medicine fridge did not have an open date recorded, to ensure they were used within a safe period
    - Oxygen stored in the treatment room, while stored securely, was blocked by a bed and a number of boxes
- To ensure that all medicinal products were administered in accordance with the directions of the prescriber of the resident concerned. For example:
    - Inspectors observed two liquid medicines were mixed together and administered to a resident. This was not the prescribed method of dispensing the medicines. In addition, the resident was not informed by the nurse that they were receiving two medicines. This practice was not in line with the centres' policy on the Crushing of Medications and Covert Medications
    - Inspectors observed that some medicines were labelled with a sticker 'shared'. However, some of these medicines were prescribed to individual residents
    - Inspectors observed that due to staffing allocation on one floor, a medicine round for one nurse was interrupted frequently which created a risk of unsafe administration
    - Poor practice was seen in single use items such as wound dressings was required as staff spoken with were unable to identify the single use symbol. In addition, inspectors observed some dressings, that were single use only, had been cut in half
- To ensure that all medicinal products which are out of date shall be stored in a safe manner, segregated from other medicinal products. For example:
    - Inspectors observed four out of date medicines stored in the medicine fridge on the day of the inspection, two of which were opened in July 2021.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A consistent approach to the recording of care plans was required to ensure that staff guidance regarding residents care was clear and systematically reviewed.

Inspectors found that seven care plans had not been reviewed within four months. Three care plans had been modified but the review dates had not been changed to reflect the modifications.

Some residents had a number of individual care plans while others had composite care plans resulting in confusion regarding where to find advice about residents care needs. One record did not provide evidence that a care plan had been followed regarding wound care. Inspectors queried the frequency of dressings and staff were unable to confirm if a dressing had been changed on the day of inspection. Following the inspection the registered provider confirmed that the care plan had not been followed.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a general practitioner who visited the centre every Wednesday. Allied health care referrals were made promptly. A physiotherapist was employed to work part-time in the centre and inspectors saw evidence that there was minimal delay in residents being reviewed. Referrals were made to the tissue viability service electronically and advice was recorded on residents records.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

In the sample of resident files reviewed, there was no evidence that explicit consent on the use of restraint had been obtained. In one file there was evidence that a family member had been told that a restraint was being used but consent was not discussed or documented. There was no evidence that restraint had been discussed with the resident and there was no care plan in place to guide staff in the use of restrictive practices.

In another example a responsive behaviour care plan review was two months overdue and consent to the use of restrictive practices had not been documented.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had taken reasonable measures to protect residents from abuse. A

safeguarding policy guided staff in their response to concerns of abuse. Staff who spoke to inspectors were knowledgeable about the policy and responses to abuse. Safeguarding concerns viewed by inspectors were fully investigated.

Judgment: Compliant

Regulation 9: Residents' rights

There was good access and opportunities for residents to participate in activities in accordance with their interests and capacities.

There was evidence of consultation with residents through monthly resident committee meetings. Inspectors reviewed a sample of these meeting records and found that residents were encouraged to provide feedback on areas such as activity provision, staff and management, care provision, meals provided and housekeeping arrangements. Information was also provided to residents on topics such as COVID-19, infection control, arrangements for visiting and fire safety.

Televisions, newspapers and radios were available for residents' use.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Clearbrook Nursing Home OSV-0005590

Inspection ID: MON-0034887

Date of inspection: 08/12/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A review of the existing staff training plan has been completed to ensure all staff have completed any outstanding mandatory training. Actions: • Staff mandatory training continues internally. • All staff requiring mandatory training have been allocated to specific scheduled training dates. Responsibility: Director of Nursing (PIC) Timeframe: 30th April 2022	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has reviewed its organisational and management structures and we are satisfied that our structures are clear and well defined and in compliance with regulation 23. An internal review will be undertaken of the governance and management structures to ensure the management of the centre is strengthened and improved.	

Actions:
• An additional Clinical Nurse Manager will be appointed to support the Director of Nursing (Person in Charge).
• Four care team leaders will be appointed to support the Director of Nursing (Person in Charge).

Responsibility: General Manager (Registered Provider Representative)
Timeframe: 30th April 2022

• All staff job descriptions to be reviewed in line with the Clearbrook organisational structure.

Responsibility: General Manager (Registered Provider Representative)
Timeframe: 31st March 2022

The Internal Quality Audit programme will be reviewed and revised to ensure a more robust programme focusing on immediate corrective and preventive actions, and continuous improvement through data analysis and shared learning.

Responsibility: Director of Nursing (Person in Charge)
Timeframe: 31st March 2022

The Internal Quality Audit Programme shall be supported by:
• Internal Quality Auditor Training Day
• Pharmacy Provided Medication Management Audits
• Externally provided quality Audit tools

Responsibility: General Manager (Registered Provider Representative)
Timeframe: 30th April 2022

An audit of compliance to these specific aspects of Regulation 23: Governance and Management shall be undertaken and all resultant actions followed up and closed out.

Responsibility: General Manager (Registered Provider Representative)
Timeframe: 30th April 2022

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
An internal review has been completed in relation to Infection Prevention and control using the Provider Self Assurance Framework against the HIQA (2018) National Standards for infection prevention and control in community services.

Actions:
• All staff to receive additional training in relation to PPE and hand hygiene practices.
• Daily communication to staff regarding the requirement not to wear watches, rings or nails during daily handover.
• Clinical hand wash basins to be replaced to meet the national standards.
• Commencement of daily IPC audits by nursing management team.
• Cleaning schedules to be reviewed and subject to ongoing audit.
• Cleaning schedules for resident equipment to be reviewed and subject to ongoing audit by team leaders.
• Cleaning schedule for sluice rooms to be to be reviewed and subject to ongoing audit by team leaders.
• Weekly medication trolley audits implemented and subject to ongoing audit by CNM and ADON.
• Cleaning schedule for medicine fridges to be developed and subject to ongoing audit to ongoing audit by CNM and ADON.
• Daily monitoring records of staff for signs and symptoms of COVID-19 to be assigned to Senior Nurse for each shift. Subject to audit by to ongoing audit by CNM and ADON.
• Internal audit findings and specific IPC audit to be completed. Lessons learned and opportunities for continuous improvement to be shared with all staff.

Responsibility: General Manager (Registered Provider Representative)
Timeframe: 30th April 2022

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
An internal review has been completed in relation to Regulation 29 Medicines and pharmaceutical services within Clearbrook.

Actions:
• All nursing staff to be reeducated in relation to all Medication Management policies and procedures.
• All nursing staff to complete HSEland Medication Management training.
• Recording of daily temperatures medication room and medication fridge temperatures to be allocated to senior nurse on each shift.
• Medication fridge contents to be reviewed to ensure all medications are labelled appropriately.
• Medication fridge contents to be reviewed to ensure all medications are not stored beyond a specified safe period.
• Weekly medication trolley audit commenced and subject to ongoing audit to ongoing audit by CNM and ADON.
• All medications to be reviewed to ensure expired medication is segregrated from other

medicinal products.
• All 'shared' medications to be reviewed by Medication Management Lead.
• Oxygen storage arrangements within medication room to be reviewed.
• Staff education in relation to single use items to be undertaken.
• Medication management audit to be completed against HIQA (2016) standards.
• Medication management audit findings to be shared with nursing team to ensure continuous improvement in relation to current practice.
• All nursing team to receive wound and dressing management training from external provider.

Responsibility: Director of Nursing (PIC)
Timeframe: 30th April 2022

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
An internal review has been completed in relation to regulation 5: Individual assessment and care planning.

Actions:
• All resident care plans to be reviewed to ensure each care plan is subject to review within four months.
• All resident care plans to be reviewed to ensure where care plans have been modified review dates have been amended to reflect modifications.
• Migration of resident individual care plans away from composite care plans to be completed.
• Ongoing care plan meetings to take place with residents and their next of kin

Responsibility: Director of Nursing (PIC)
Timeframe: 30th April 2022

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
An internal review in relation to regulation 7: Managing behaviour that is challenging has

been completed.

Actions:
• A review of residents subject to any form of restrain to be undertaken.
• Consent to be obtained in relation to all forms of restraint and documented.
• All resident care plans in relation to responsive behaviour to be reviewed and updated where neccesary.
• Care plans to be developed in relation to any resident subject to the use of restrictive practices.
• An internal audit of regulation 7: Managing behaviour that is challenging shall be completed. Audit findings, corrective and preventative actions to be shared with nursing team to ensure continuous improvement.

Responsibility: Director of Nursing (PIC)
Timeframe: 30th April 2022

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/04/2022
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	Not Compliant	Orange	30/04/2022

	staff.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	30/04/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	30/04/2022
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger	Not Compliant	Orange	30/04/2022

	to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	30/04/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/04/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/04/2022