

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Woodlands Nursing Home
Centre ID:	OSV-0000304
Centre address:	Bishops wood, Dundrum, Tipperary.
Telephone number:	062 71 335
Email address:	info@wnh.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Tipperary Healthcare Limited
Provider Nominee:	Paddy Fitzgerald
Lead inspector:	Sonia McCague
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 19 April 2016 09:00 To: 19 April 2016 17:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This inspection was unannounced and took place over one day. The purpose of the inspection was to monitor ongoing regulatory compliance within 10 outcomes.

At the commencement of this inspection, the inspector met with staff on duty to inform them of the purpose of the inspection. On arrival of the person in charge and provider nominee the inspector informed them of the purpose of the inspection. The centre is registered for 43 residents. On the day of inspection there were 37 residents in the centre, two residents were in hospital and four vacancies were reported.

The inspector met and spoke with residents and staff during this inspection. Residents who spoke with the inspector expressed satisfaction with the care and services provided and were complimentary of the staff group. Policy documents and resident, staff and general records were reviewed as part of this inspection.

The previous inspection of this centre was carried out 06 August 2014 and focused

on end of life care and food and nutrition. The required actions from the previous inspection were followed up on this inspection. An action in relation to the provision of and review of care plans had not been addressed sufficiently and is restated.

As a result of this inspection, non compliances with the Health Act 2007 and regulations were found in relation to:

- the governance and management of the centre
- statement of purpose and function
- skill mix, supervision, and training arrangements for staff
- infection prevention and control procedures
- medication management
- assessment, care planning and access to appropriate treatment or care
- maintenance of records, directory of visitors and recruitment records of staff.

The annual review of the quality and safety of care delivered to residents required development to inform quality improvements.

Findings were provided to the person in charge and provider nominee on the day of inspection. The areas for improvement are outlined in the body of this report and summarised in the action plan at the end for response.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A hard copy of the statement of purpose (SOP) was not readily available to the inspector, staff and residents on the day of the inspection. However, an electronic copy was available on request.

The person in charge told the inspector that the statement of purpose had not been revised since the application submitted to register the designated centre in 2013. This is discussed further in outcome 2.

A reviewed and or revised copy was to be submitted to the HIQA following this inspection. However, a copy had not been submitted at the time of issuing this report.

Judgment:

Non Compliant - Moderate

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Improvements were required to ensure that the service provided was safe, appropriate

to residents' needs, consistent and effectively monitored.

Operational and management arrangements were described and in place. However, deficiencies were found in relation to the provision of skilled nursing staff available to meet the high dependency needs of residents in accordance with the statement of purpose.

Suitable contingency measures had not been put in place for planned leave to ensure the person in charge maintained a supernumerary role to ensure the centre was consistently managed and effectively governed.

The nursing staff resources in whole time equivalent (WTE) hours outlined within the SOP received with the application of registration in 2013 were not available in practice. Eight nurse WTE's were outlined in the SOP. However, 3.5 were available and rostered on the week of this inspection and available on the following week's planned roster. As a result, the person in charge confirmed and was rostered to cover nursing shifts (one day and three nights for both weeks). Any unplanned absence of the person in charge or nurses available would compromise resident's safety and quality of care.

Risks and challenges identified and known such as planned or long term leave of skilled staff nurses had not been sufficiently managed to ensure sufficient or consistent resources were maintained as required. The inspector was informed that a person participating in the management of the centre was on planned long term leave and that two nurses had ceased working in the centre the previous Friday to pursue careers elsewhere. Advance notice to the provider and person in charge for recent leave arrangements and or the termination of their employment was known in advance. The inspector was told that four nurses had ended their employment or completed their contract with this centre in the past six months. The recruitment of four staff to fill nurse posts was described as in process. However, those described as recruited were not all working in the centre and all were described as awaiting registration to practice as a nurse in Ireland. Evidence to verify a nursing qualification was not available in the centre.

The provider nominee and person in charge described how they had experienced delays of up to six to eight months for nursing registration of previously recruited staff members as nurses. However, suitable contingency measures such as reducing resident numbers or ceasing respite admissions and or the admission of residents with a high dependency and nursing care needs had not been considered. Residents for respite and those with high dependency nursing needs had been admitted to the centre in days and weeks prior to this inspection.

An annual review of the quality and safety of care delivered to residents in the designated centre was made available. However, improvements were required in relation to the lack of statistical and quantitative data to inform trends and future quality improvements.

Judgment:
Non Compliant - Major

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector observed that while many records listed in the regulations were available in the centre, some improvements were required to ensure they were completed accurately and maintained in accordance with professional guidelines.

Improvements were required in relation to the following:

Clinical records that included wound and pressure ulcer assessments by the nurse on duty and care given were not up to date or recorded in accordance with relevant professional guidelines.

A record of all visitors to the designated centre, including the names of visitors was not maintained. The last recorded entry in the register of visitors to the centre was dated June and December 2015, as required under regulation 21, schedule 4 (12).

The inspector reviewed operating policies and procedures for the centre, as required by schedule 5 of the regulations. Policies listed in Schedule 5 were in place, including those on health and safety and risk management, medication management, use of restraint, management of complaints and the prevention, detection and response to abuse. Many of these policies had recently been reviewed by the person in charge.

Policies and procedures relating to the recruitment, selection and vetting of staff were described and in place and a record of current registration details of nursing staff was maintained. While a recent audit of staff files had been completed to identify gaps and inform improvement, not all documents required under Schedule 2 of the Regulations were contained in the sample of staff personnel files reviewed.

The following matters were not available as required under regulation 14, 15 and 21 in some staff files that were reviewed:

- Evidence of the person's identity, including his or her full name, address, date of birth and a recent photograph as required under schedule 2 (1)

- A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 as required under schedule 2 (2)
- Details and documentary evidence of any relevant qualifications or accredited training of the person as required under schedule 2 (3)
- A full employment history, together with a satisfactory history of any gaps in employment as required under schedule 2 (5)
- A contract of employment to include staff position or work to be performed and the commencement date had not been completed for all as required under schedule 4 (8).

Judgment:

Non Compliant - Moderate

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Measures to protect and safeguard residents were described and demonstrated in practice. Policies and procedures were in place and kept under review by the person in charge.

The inspector was informed there were no active incidents, allegations, or suspicions of abuse under investigation. Residents who spoke with the inspector said they felt safe.

The person in charge told the inspector she delivered training to staff on an annual basis. Staff knew what constituted abuse and described what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. The staff training records reviewed showed that training in relation to the detection and prevention of and responses to abuse was provided.

A policy was available in relation to managing behaviours that challenged. The person in charge told the inspector there were no specific incidents reported where residents' behaviours had challenged staff. She described some residents that required more encouragement than others with activities of general living such as washing, dressing, eating and drinking.

A policy was available in relation to the use of restraint and a register of restraint use was maintained. Measures of restraint such as bedrails that restrict the freedom of residents' movement were observed in use by residents in bed. The inspector noted that

risk assessments had been undertaken and recorded to inform the decisions in relation to the use of restraint.

Judgment:

Compliant

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The centre had policies and procedures relating to health and safety. There were policies and procedures in place for risk management and emergency planning.

Audit systems to monitor clinical outcomes were in place to provide an opportunity for learning and improvement. Arrangements were in place for reviewing, investigating and learning from incidents or adverse events involving residents to achieve an overall reduction of likely incidents and possible adverse events such as weight loss and falls. However, the inspectors identified some additional risks which needed to be addressed.

The inspector observed that the call bell system for residents to seek staff assistance was not available at all resident's beds or in communal places occupied by residents. On examination and activation of the call bell system, the inspector found a discrepancy in the identification of bed and room numbers on staff pagers with the actual room location where the call bell was activated from. Staff present witnessed the discrepancy and the provider nominee and person in charge were to follow up on this matter immediately. The position of wall mounted television brackets at a low level over chairs and over the head of beds required assessment and review to ensure adequate quality control measures.

Policies, practices and procedures were described in relation to the prevention and control of infection. Staff attendance at training in infection prevention and control had been recorded for some staff in 2015. However, improvements were required to ensure best practice in infection prevention, control and response was maintained in accordance with national guidelines.

On arrival to the entrance of the centre, the inspector saw a notice on display dated 17/04/2016 restricting visitors due to signs and symptoms of a viral infection. Some staff had also been on sick leave. The authority had not been notified of this. On enquiry, staff told the inspector that between 11 and 15 residents had been affected. However, a referral of the outbreak had not been made to public health professionals for surveillance, advice and support regarding the need to investigate possible factors. Staff

confirmed that microbiological samples to investigate or diagnose the cause had not been obtained or sent to a laboratory for testing. The inspector was subsequently notified that the general practitioner had diagnosed gastroenteritis and that six residents had been affected.

On inspection of the centre, the inspector saw a number of arrangements that did not promote prevention and control of infection such as:

- toothbrushes and razors of residents in twin rooms seen stored in a shared container
- a bar of soap seen on the wash hand basin in the sluice room that was not locked
- open waste bins seen in communal, clinical and sluice rooms
- the covering of a commode lid was torn -potential to harbour infection
- a limited availability to hand sanitisers and easy access to hand washing facilities was found
- the paintwork on walls and on ceilings in parts was damaged, flaked or worn
- urine drainage bags in use by two residents were not adequately supported and one was seen in contact with the floor.

A fire safety register and associated records were maintained and precautions against the risk of fire were in place and described. Service records confirmed that the fire alarm system and fire safety equipment including emergency lighting and extinguishers were serviced appropriately and serviced on a regular basis. There were adequate means of escape, including emergency lighting, and fire exits which were unobstructed.

Evacuation plans and emergency procedures required for each resident were completed and retained in an equipped emergency box. The summary list within was due to be updated. However, training in fire safety and simulated evacuation drills had not been completed in 2016 or completed in 2015 by up to 12 staff that were rostered and working in the centre. The provider nominee and person in charge acknowledged this finding and were to address this requirement following feedback. The person in charge has since confirmed that a fire drill was carried out by staff on 2 May 2016 and that fire safety training was planned for all staff .

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Policies, procedures and practices were in place and described by staff in relation to medication management. However, improvement was required regarding some

medication management practices to ensure that each resident was protected by the centre's procedures.

Arrangements were in place and described for the prescribing, ordering, administration, storage and disposal of prescription medication. Systems were described and in place to review prescribed medication by the general practitioner and pharmacist. All controlled (MDA) medicines were stored in a secure cabinet, and a register of these medicines was maintained with the stock balances checked and signed by two nurses at the end of each working shift.

At the time of the inspection none of the residents in the centre were self administering medicines.

Storage facilities included a key locked room to store controlled medicines safely, a secure medicine trolley and a fridge for medications that required specific temperature control was provided. Medicines were supplied to the centre by a retail pharmacy business with the majority of residents' medicines dispensed in a monitored dosage system. However, prescription medicines dispensed for up to five residents that included sedative medicines had not been administered and were found accessible in a nearby room that was not locked or secure.

The inspector saw that medicines dispensed for up to five residents in a monitored dosage system had not been administered over a number of days. The person in charge told the inspector they were in the room to be collected or returned to the pharmacy. The rationale provided by the person in charge for surplus medicines in two residents dosage systems was that one resident had been out of the centre elsewhere and one had been in hospital. These medicines were immediately removed from the unsecure room and placed into a secure room.

The disposal of other medicines also required improvement. Prescription medicine, some dated as dispensed in January, March and June of 2015 remained in stock for persons who were not residents in the centre. In addition, the inspector observed that dates of opening were not marked on medicines when required for existing residents, including prescribed eye drops, cream or liquid medicines.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Notification required under regulation 31 and as outlined in schedule 4 of regulation 21, had not been reported to the Chief Inspector.

An incident whereby a resident developed pressure ulcers had not been notified to HIQA in 2015 as required.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

Some improvements were required to ensure the healthcare and social care needs of residents were facilitated.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was shared between providers and services.

There was evidence that the admission of residents into the centre was managed by the person in charge. Staff told the inspector that residents and their family were involved in planning for their placement. A visit to the centre before admission was generally encouraged.

Health and social care arrangements and resident records available were reviewed and discussed with residents and staff. Some improvement was required in the overall assessment, planning, referral and evaluation of care on and following admission of residents to the centre.

In a sample of residents' records reviewed and discussed with staff, the inspector found that the assessments and clinical care did not consistently accord with evidence based practice. The recording of clinical practice did not reflect professional guidelines issued

by An Bord Altranais agus Cnáimhseachais to ensure information was individualised, accurate, up to date on the daily basis with factual information.

A comprehensive assessment to determine all the needs of a resident prior to or on admission to ensure the service was suitably and sufficiently equipped to provide an appropriate plan of care had not been sufficiently completed, and for some, little evidence that admissions were subject to a review accordingly. For example, a comprehensive assessment to include the physical and social care needs of each resident had not been sufficiently detailed to ensure all the needs of the resident were met.

In the sample of resident daily records reviewed, a repeated entry for five days in one week described the resident as 'cross'. This information was based on summation and not factual. The behaviour of the resident described as 'cross' was unclear and not reflected in a care plan to support the identified needs of the resident.

Assessment details and records that included daily evaluation and clinical care records were incomplete, unavailable or insufficiently maintained or linked in a related or specific care plan to guide practice and inform an assessment or review. For example, the assessment of wounds and pressure ulcers had not been completed to demonstrate appropriate care and or a review of the sites had been undertaken for up to 18 days. Staff were unable to inform the inspector of the actual status, grade or classifications of the pressure ulcers on enquiry. The available records and information did not provide sufficient detail to enable any person inspecting the record to determine the condition of the pressure sores, the treatment being provided or plan to promote healing. The initial care plan date showed that a resident developed a pressure sore in the centre in September 2015. The pressure relieving equipment in use and arrangements in place had not been reviewed or evaluated. HIQA had not been notified as required. While clinicians such as the dietician and the speech and language therapist were available, a referral to a tissue viability specialist for assessment had not been facilitated despite significant deterioration in the resident's condition.

In the sample of care plans reviewed, such as, wound care, vulnerability to pressure ulcers, food and nutrition and modified diets, end of life, falls risk due to grand mal seizures and use of bedrails, they were not sufficiently detailed or completed to inform an appropriate evaluation or review of care provided. For example, a care plan dated July 2012 was last modified in July 2014 in relation to falls due to grand mal seizure activity. However, there was no evidence that a review or an evaluation of a care plan was carried out to include if the resident had seizure episodes, the number of seizures or duration since the last modification date in 2014.

Improvement was required to ensure care plans had been completed after consultation with the resident concerned and prior to the resident's family. For example, an end of life care plan for one resident reflected the views of their relative. The functional capacity or views of the resident in relation to this plan were not stated. However, this resident's care plan regarding the decision and use of a restraint had been signed by the resident on a later date to the end of life plan.

Residents had access to a range of allied health care services on referral that included

weekly physiotherapy, occupational therapy, psychiatry, chiropody, optician, dental and social work. However, access to a tissue viability specialist had not been available. Suitable and sufficient arrangements were not in place to facilitate a resident with multiple pressure ulcers timely access to health care services and appropriate treatment. There was no referral or record of referral of this resident to allied services such as tissue viability or a wound care specialist. The inspector was subsequently informed that a referral was made since this inspection.

The location, level of support and supervision arrangements that included a listening device used to monitor a resident with high dependency nursing needs required review to ensure suitable and sufficient care is available that encourages the prevention and early detection of ill health.

A structured or planned social activity to promote the social care needs of residents was limited on the day of inspection. The inspector was informed that the activity staff member was on sick leave. Contingency plans to promote and support the social care needs of residents on the daily basis required review. For example, efforts and arrangements to ensure residents have the choice in rooms for dining, lounging or performing group or individual activities should be available and provided. The inspector saw that a number of residents had their meals brought to them in the day room where they were seated since morning. A bedside table was used as the dining table for some residents that remained in the day room. Meal times as a social occasion and the dining experience for these residents required improvement.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Policies and procedures were in place for the management of complaints. A record of complaints, investigations, responses and outcomes was maintained.

The inspector was informed by the person in charge who was the complaints officer that issues of concern or complaints received since the last inspection had been managed in accordance with the centre's policy and were resolved to the satisfaction of the complainant. The complaints log maintained and reviewed by the inspector confirmed this.

The inspector was also informed that the complaints of each resident, their family, advocate or representative and of visitors were listened to and acted upon. There were no active complaints in relation to residents being investigated at the time of inspection.

The complaints policy was available in the centre and an appeals process was included in this procedure.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

A record of resident dependency levels, staff rosters with staffing levels and training programmes were maintained and monitored by the person in charge to inform staffing arrangements.

Staffing levels and skill mix at time of this inspection were adequate to meet the needs of residents. However, as outlined in outcome 2, management and governance of nursing staff provision required improvement.

A programme of training was reported and co-ordinated by the person in charge. However, a training needs analysis specific to the staff working in this centre was required as the records included those employed elsewhere by the provider. Based on the inspection findings, training deficiencies and knowledge gaps specific to recording clinical practice, wound care and assessment, infection prevention and control practices and medication management was required along with improved supervision arrangements. Staff training status in cardio pulmonary resuscitation was not available or known.

Some staff were not sufficiently informed of residents needs or changes in their condition and had not received a handover report. Communication or reports for staff that returned to work after a period of leave and prior to delivery of care required improvement. For example, the most up-to-date dietary requirements and condition of

residents' skin was not known by relevant staff responsible for the delivery of care and support. Staff observed supporting residents to eat and drink had not received proper communication in relation to their changing needs and recommendations from allied health professionals regarding a modified diet and fluid consistency. The promotion and provision of person centred care was required to avoid task orientated practice such as a staff member allocated to 'feeds' and address the use of inappropriate language such as 'pet' and signage and assessments of 'cotside' used.

Recruitment procedures were described as in place. However, as outlined in outcome 5, improvements were required to ensure the records for staff required in schedule 2 were available and maintained in the centre.

The inspector was informed there were no people involved on a voluntary basis within the centre at this time.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Sonia McCague
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Woodlands Nursing Home
Centre ID:	OSV-0000304
Date of inspection:	19/04/2016
Date of response:	20/05/2016

Requirements

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

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

Outcome 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The statement of purpose had not been reviewed or revised since the application submitted to register the designated centre in 2013.

1. Action Required:

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

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

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

A revised Statement of Purpose sent to HIQA.

Proposed Timescale: 20/05/2016

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Deficiencies were found in relation to the provision of skilled nursing staff available to meet the high dependency needs of residents in accordance with the statement of purpose.

The nursing staff resources in whole time equivalent (WTE) hours outlined within the SOP received with the application of registration in 2013 were not available in practice. Eight nurse WTE's were outlined in the SOP. However, 3.5 were available and rostered on the week of this inspection and available on the planned roster for the following week.

The person in charge confirmed and was rostered to cover up to 40 hours of nursing shifts (day and night) for two consecutive weeks.

Any unplanned absence of the person in charge or nurses available would compromise resident's safety and quality of care.

2. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

We are acutely aware of our shortage of Staff Nurses at present. Since the day we were informed that 2 Staff Nurses were leaving, we have been actively trying to recruit staff. We have advertised locally and nationally. We have contacted agencies and through them have retained the services of 3 qualified nurses awaiting registration. However because of the delay in getting registered with NMBI we have been left in short supply.

We have interviewed another Nurse who is due in Ireland at the end of May.

Since the inspection we have a staff nurse starting, full time on 29th May 2016.

We have also found 2 local staff nurses who will work part time until our staff nurses have been registered. Our ADON is due back from Maternity Leave at the end of June.

When all of these are in place we will have WTE of 8 Staff Nurses plus DON

We shall continue to actively recruit nurses creating a surplus to ensure no shortages in the future.

We are keeping our bed occupancy at 86% until staffing levels improve.

Proposed Timescale: 20/05/2016

Theme:

Governance, Leadership and Management

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

Suitable contingency measures had not been put in place for planned leave to ensure the person in charge maintained a supernumerary role to ensure the centre was consistently managed and effectively governed.

3. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

When the ADON went on Maternity leave we assumed that the second ADON and DON would manage the centre. However we were not expecting Staff nurses to leave and create such a shortage.

We shall endeavour to ensure that this doesn't occur again by promoting a suitable candidate as a temporary ADON if the situation does occur.

Proposed Timescale: 20/05/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

A record of all visitors to the designated centre, including the names of visitors was not maintained. The last recorded entry in the register of visitors to the centre was dated June and December 2015, as required under regulation 21, schedule 4 (12).

4. Action Required:

Under Regulation 21(4) you are required to: Retain the records set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4 for a period of not less than 4 years from the date of their making.

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

We have put up signage to highlight the visitors book and are reminding visitors as we see them to sign in and out.

Proposed Timescale: 20/05/2016

Theme:

Governance, Leadership and Management

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

Clinical records that included wound and pressure ulcer assessments by the nurse on duty and care given were not up to date or recorded in accordance with relevant professional guidelines.

The following records required were not available in some staff files that were reviewed:

- Evidence of the person's identity, including his or her full name, address, date of birth and a recent photograph as required under schedule 2 (1)
- A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 as required under schedule 2 (2)
- Details and documentary evidence of any relevant qualifications or accredited training of the person as required under schedule 2 (3)
- A full employment history, together with a satisfactory history of any gaps in employment as required under schedule 2 (5)
- A contract of employment to include staff position or work to be performed and the commencement date had not been completed for all as required under schedule 4 (8).

5. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

We are in the process of reviewing all clinical records and have highlighted to all staff deficiencies found. We will have a staff meeting with all nurses informing them of the importance of documentary compliance in all areas

An Audit has been compiled on our staff files. Missing documentation has been noted and where files are not complete, staff have been requested to provide missing documents. In the case of Garda vetting, certs have been issued for clearance, however, we have been informed by NHI of a change of process, which is delaying the return of the certs. There is a changeover to applying online as opposed to postal application.

The Registered Provider has applied for permission to the Garda Clearance section to allow us to make direct online applications to speed up the process.

Proposed Timescale: 01/07/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The inspector observed that the call bell system for residents to seek staff assistance was not available at all resident's beds or in communal places occupied by residents.

On examination and activation of the call bell system, the inspector found a discrepancy in the identification of bed and room numbers on staff pagers with the actual room location where the call bell was activated from.

The position of wall mounted television brackets at a low level over chairs and over the head of beds required assessment and review to ensure adequate quality control measures.

6. Action Required:

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

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

An Audit of all call bells has been completed and all discrepancies noted. We have contacted our call bell provider to supply us with a full complement of call bells.

We have removed the low level Television bracket. (This room has been renovated since inspection)

An Audit has been developed to assess Electrical equipment in rooms including positioning, safety etc.

Proposed Timescale: 01/07/2016

Theme:

Safe care and support

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

Improvements were required to ensure best practice in infection prevention, control and response was maintained in accordance with national guidelines.

Staff told the inspector that between 11 and 15 residents had been affected with symptoms of a viral infection over the previous weekend. Some staff had been off on sick leave.

A referral of the outbreak had not been made to public health professionals for advice and support regarding the need to investigate possible factors or surveillance .

Microbiological samples to investigate or diagnose the cause had not been obtained or sent to a laboratory for testing.

On inspection of the centre, the inspector saw a number of arrangements that did not promote prevention and control of infection such as:

- toothbrushes and razors of residents in twin rooms seen stored in a shared container
- a bar of soap seen on the wash hand basin in the sluice room that was not locked
- open waste bins seen in communal, clinical and sluice rooms
- the covering of a commode lid was torn -potential to harbour infection
- a limited availability to hand sanitisers and easy access to hand washing facilities was found
- the paintwork on walls and on ceilings in parts was damaged, flaked or worn
- urine drainage bags in use by two residents were not adequately supported and one was seen in contact with the floor.

7. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

Labelled containers have been provided in rooms for toothbrushes and razors.

All staff have been notified that bars of soap are not to be used in Woodlands

All open bins in communal, clinical and sluice areas have been removed.

The covering of the commode that was torn has been sent for repair.

We currently have 7 hand sanitisers around the building and will put up a further 4.

We have hand washing sinks in every bedroom (28) and a further five in ancillary areas.

We also have 9 hand washing sinks in bathrooms.

All paintwork will be repaired.

All staff have been notified that urine drainage bags must be properly supported.

We shall audit all infection control procedures.

We shall ensure that all staff are up to date in infection control training.

Proposed Timescale: 01/09/2016

Theme:

Safe care and support

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

Training in fire safety and simulated evacuation drills had not been completed in 2016.

Fire safety training or drills completed in 2015 did not include 12 staff members that were rostered and working in the centre.

8. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the

designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Following advice from the inspector we have appointed a Fire Warden from our existing staff. He will be trained by a fire safety firm as a Fire Warden and will have responsibility for staff fire drill training.

We have, in the meantime, carried out 2 fire drills to keep staff up to date.

A fire safety firm have been engaged to provide a fire training day for all staff.

Each staff member is also required to complete a fire safety online course and test annually. We are currently auditing this to ensure it is up to date.

Proposed Timescale: 01/08/2016

Outcome 09: Medication Management

Theme:

Safe care and support

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

Prescription medicines dispensed for up to five residents that included sedatives were not stored in a secure place.

The inspector saw that medicines dispensed for up to five residents in a monitored dosage system had not been administered over a number of days within the monthly supply.

9. Action Required:

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

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

We are reviewing practices in regards to storing medication and will ensure that all medications are stored securely

Proposed Timescale: 01/07/2016

Theme:

Safe care and support

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

The disposal of medicines not in use required improvement.

Prescription medicine, some dated as dispensed in January, March and June of 2015 remained in stock for persons who were not residents in the centre.

The inspector dates of opening were not marked on medicines required for existing residents, including prescribed eye drops, cream or liquid medicines.

10. Action Required:

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

We are completing an audit of Medication management including disposal of medication. Initially we have disposed of all medication that was no longer in use. We have told all staff that dates of opening must be marked on eye drops, creams and liquids.

Proposed Timescale: 01/07/2016

Theme:

Safe care and support

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

It was unclear why the prescription medicines dispensed by the pharmacy for five residents had not been administered.

11. Action Required:

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

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

All residents receive medication as prescribed.

As we informed the Inspector on the day, the left over Medication was belonging to residents who were off site and whose medication was being supplied elsewhere on the days in question. These absences can be checked in our records.

We are currently auditing our medication management procedures to ensure compliance with best practice.

Proposed Timescale: 20/05/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

An incident whereby a resident developed pressure ulcers had not been notified to HIQA in 2015 as required.

12. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

We have since sent notification to the chief inspector (NFO3)

We shall ensure that all incidents are reported to the chief inspector as necessary

Proposed Timescale: 20/05/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

A comprehensive assessment to determine all the needs of a resident prior to or on admission to ensure the service was suitably and sufficiently equipped to provide an appropriate plan of care had not been sufficiently completed, and for some, little evidence that admissions were subject to a review accordingly.

A comprehensive assessment to include all the support and social needs of each resident had not been sufficiently detailed to ensure all the needs of the resident were met.

Assessment details and records that included daily evaluation and clinical care records were incomplete, unavailable or insufficiently maintained or linked in a related or specific care plan to guide practice and inform an assessment or review.

The assessment of wounds and pressure ulcers had not been completed to demonstrate appropriate care and or a review of the sites had been undertaken for up to 18 days. Staff were unable to inform the inspector of the actual status, grade or classifications of the pressure ulcers on enquiry.

The available records and information did not provide sufficient detail to enable any person inspecting the record to determine the condition of the pressure sores, the

treatment being provided or plan to promote healing.

The location, level of support and supervision arrangements to monitor a resident with high dependency nursing needs required review to ensure suitable and sufficient care is available that encourages the prevention and early detection of ill health.

13. Action Required:

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

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

We are currently auditing all assessments and care plans to ensure best practice. Staff nurses that have not completed Wound management training have been registered for training in September.

We are currently running an in-house training on pressure sore prevention for all care staff.

We have renovated a room nearer to the Nurses station to ensure closer monitoring.

Proposed Timescale: 30/09/2016

Theme:

Effective care and support

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

The behaviour of a resident described as 'cross' was unclear and not reflected in a care plan to support the identified needs of the resident.

The sample of care plans reviewed, such as, wound care, vulnerability to pressure ulcers, food and nutrition and modified diets, end of life, falls risk due to grand mal seizures and use of bedrails, were not sufficiently detailed or completed to inform an appropriate evaluation or review of care provided.

14. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

We are currently auditing all our clinical records to improve same.

We are meeting with all Staff nurses to improve the development of care plans.

Proposed Timescale: 01/07/2016

Theme:

Effective care and support

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

Improvement was required to ensure care plans had been completed after consultation with the resident concerned and prior to the resident's family.

There was no evidence that a review or an evaluation of a care plan dated July 2012 and last modified in July 2014 in relation to falls due to grand mal seizure activity was carried out to include if the resident had seizure episodes, the number of seizures or duration since the last modification date in 2014.

15. Action Required:

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

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

All care plans are evaluated at a minimum of every 4 months.

During Resident discussions we discuss Residents care plans and ask for their input.

Please find attached evaluations of afore mentioned care plan. Appendix 2

We are constantly auditing all care plans to ensure they are in line with best practice.

This is assisted by our Epicare system which provides reminders to evaluate care plans.

An Audit of all care plans will be carried out to ensure best practice.

Proposed Timescale: 01/07/2016

Theme:

Effective care and support

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

Access or referral to a tissue viability specialist for assessment had not been facilitated at the time of inspection despite significant deterioration in a resident's condition.

16. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

We have contacted a tissue viability Nurse who will assist us by devising a care plan for residents.

Proposed Timescale: 01/07/2016

Theme:

Effective care and support

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

Nursing assessments and clinical care did not consistently accord with evidence based practice.

The recording of clinical practice did not reflect professional guidelines issued by An Bord Altranais agus Cnáimhseachais to ensure information was individualised, accurate, up to date on the daily basis with factual information.

A structured or planned social activity programme to promote the social care needs of residents was limited on the day of inspection.

17. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

We are Auditing all our assessments to ensure they are in line with best practice. We shall also Audit our recording of clinical care.

We have a varied activities programme 5 days a week. On the day of inspection our Activities Co-Ordinator had called in sick. Details of her hours worked are available via our clock in system if necessary. We are very happy with our level of activities and have received numerous compliments from residents and families regarding same. We recognise the importance of a social activity programme for all residents. If we have prior knowledge of the absence of the Activities co-ordinator we always provide cover. However in this instance we were only informed that morning.

Proposed Timescale: 01/07/2016

Outcome 18: Suitable Staffing**Theme:**

Workforce

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

A training needs analysis specific to the staff working in this centre was required as the records included those employed elsewhere by the provider.

Based on the inspection findings, training deficiencies and knowledge gaps specific to recording clinical practice, wound assessment and management, infection prevention and control practices and medication management was required along with improved supervision arrangements.

The status of staff training in cardio pulmonary resuscitation was not available or known by the person in charge.

18. Action Required:

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

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

We are currently auditing our training files to identify gaps. We shall ensure that all staff are trained as required and monitor same to identify further training that may be needed.

Proposed Timescale: 01/07/2016

Theme:

Workforce

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

As outlined in outcome 2, due to a nursing staff shortage, the person in charge was not available to supervise staff and care being delivered on a daily basis as when working as the only nurse on duty.

Some staff were not sufficiently informed of residents needs or changes in conditions and had not received a handover at the commencement of their shift.

Communication or reports for staff that returned to work after a period of leave and prior to delivery of care required improvement. Staff observed supporting residents with food and nutrition had not received proper communication in relation to their changing needs and recommendations from allied health professionals regarding a modified diet and fluid consistency.

The promotion and provision of person centred care was required to avoid task orientated practice such as a staff member allocated to 'feeds' and address the use of inappropriate language such as 'pet' and signage and assessments of 'cotside' used.

19. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

All care staff receive a handover before commencing duty. We recognise that all other staff (i.e. Catering staff) should be included to ensure they are aware of changing conditions. From 24/4/15 this system is in place.

We shall continue to communicate changing needs in regard to modified diet and fluid consistency. All modifications are stated in residents diet plans stored in the kitchen and all staff are familiar with same. There is also a pictorial summary of diet and fluid

modifications in the kitchen and kitchenette (Off day room) to better communicate resident diet modifications.

We have spoken to staff in regards to language used in the centre and are aware that certain terms, while used in an affectionate manner, may be considered by some as demeaning. We shall change our signage and use of terms i.e. " cot-sides" and " feeds "

Proposed Timescale: 01/07/2016