Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Willowbrook Lodge
Centre ID:	OSV-0000302
Centre address:	Mocklershill, Fethard, Tipperary.
Telephone number:	062 615 60
Email address:	info@willowbrooklodge.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	NSK Healthcare Limited
Provider Nominee:	Noelle Killeen
Lead inspector:	Una Fitzgerald
Support inspector(s):	Sonia McCague
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	2

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
29 March 2017 09:10	29 March 2017 18:40

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant
Outcome 08: Governance and Management		Non Compliant - Moderate

Summary of findings from this inspection

This thematic inspection focused on the care and welfare of residents who had dementia. On arrival to the centre, inspectors met with the representative for the registered provider and person in charge of the centre who were informed of the purpose of the inspection. Prior to the inspection, the centre completed the provider's self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016). The previous table outlines the centre's rating and the inspector's rating for each outcome. Due to the findings on the day the inspectors have also included Outcome 8 Governance and Management within the report.

The inspectors met with residents and staff members during the inspection. The case files of a number of residents with dementia within the service were tracked. A validated observation tool was used to observe practices and interactions between staff and residents within the centre. Specific emphasis focused on residents who had dementia. Documentation such as care plans, medicine records, medical and clinical records, policies and procedures, and staff training records were reviewed.

Willowbrook Lodge is a registered designated centre that provides care for a maximum of 26 residents. On the day of inspection there was a total of 6 residents with a formal diagnosis of dementia and a further 3 residents who have symptoms of dementia.

The inspectors observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. However, major non-compliance was found within Outcome 1 Health and Social care needs specific to medicine management practices which is discussed in detail within the body of the report. As a result the centre was required to take immediate action and the provider was issued with an Immediate Action plan to provide a written assurance to the Chief Inspector that the failings identified were addressed immediately. The action plan response returned included that all medicinal products were being administered in accordance with the directions of the prescriber for all residents in the centre from 3pm on 31 March 2017.

A review and improvement plan in relation to the governance arrangements was required to ensure effective delivery of care and protection of residents from potential harm related to medicine management practices. Inadequate planning from the pre-admission stage was also found.

Staff observed were courteous and responsive to residents and visitors during the inspection. The results from the formal and informal observations were positive and staff interactions with residents promoted positive connective care. In general the living environment was stimulating and also provided opportunities for rest and recreation in an atmosphere of friendliness.

A range of staff training opportunities included dementia specific training courses were provided. There was appropriate staff numbers on duty on the day of inspection. However, based on the findings, a review and improvement in relation to the overall staffing compliment on an ongoing basis was required to ensure appropriate governance, oversight, monitoring of quality care and supervision arrangements.

The findings and improvements required are discussed within the body of this report and set out 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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to assessments and care planning, access to medical practitioners and healthcare, maintenance of records and policies available governing practice. The social care of residents with dementia is reported in Outcome 3.

The self assessment tool (SAT) completed by the provider was rated compliant in this outcome with no areas for improvement highlighted.

Inspectors focused on the experience of residents with dementia and they tracked the journey prior to and from admission of residents. They also reviewed specific aspects of care such as nutrition, mobility, access to health care and supports, medication management, end-of-life care, maintenance of records and adoption of approved policies and professional standards.

Pre-admission arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. The person in charge visited prospective residents prior to admission to assess and determine their needs. This arrangement gave the resident and carer or their family an opportunity to meet in person, provide information about the centre and assess or determine if the service could adequately meet the needs of the resident. However, some improvement in the pre-admission assessment was required to ensure adequate and required arrangements were in place to ensure suitable and sufficient access to medical services was available and determined for each resident. This is discussed further in relation the management of medicines and review of treatment.

An admission policy approved 20 August 2012 and reviewed 23 September 2016 was available to guide practice. While many aspects of the policy was reflected in practice, improvement was required to ensure information from and liaison with the perspective resident's general practitioner (GP) or transferring hospital was obtained for planned or following emergency admissions (within 72 hours) in accordance with this policy. Inspectors found inconsistencies in relation to the gathering of relevant information

related to medicines prescribed and current treatment recommended.

Records available pertaining to each resident were made available for inspection. Some residents' files held a copy of their hospital discharge letters (medical, allied healthcare and nursing). However, the files of residents admitted under 'Fair deal' did not include the copy of the Common Summary Assessments (CSARS), which details assessments undertaken by professionals such as a geriatrician, a medical social worker and nurse. An improvement in requesting a copy of the CSARS for future prospective residents was acknowledged by the person in charge.

Residents had a comprehensive nursing assessment completed on admission. The assessment process involved the identification of significant persons for contacting and the use of validated tools to assess each resident's dependency level, risk of malnutrition, falls and their skin integrity. An assessment of cognitive functioning and impairment of residents admitted with a diagnosis of dementia was recorded and subject to a regular review by nurses.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to allied healthcare professionals including physiotherapy, occupational therapy (OT), dietetic, speech and language dental, ophthalmology and podiatry services were available on a referral basis. Inspectors were informed that residents had access to psychiatry of old age services. From the cases tracked it was evident that these services were available to some residents prior to their admission and as required thereafter.

A medical practitioner chosen by or acceptable to each resident was available. However, based on the findings access to a medical practitioner or GP was not timely resulting in unsafe medicine management practices. Inspectors concluded that the medical arrangements provided were not sufficiently adequate or timely to ensure appropriate medical care was consistently provided to residents. For example, the most recent medical record for one resident was January 2016 and a subsequent communication in 2017 regarding a significant decision was issued by fax in the absence of any record of an ongoing assessment or review.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Functional assessments were carried out on admission of residents. The initial assessment was subject to regular reviews; however, changes evident since the initial assessment were not sufficiently reflected within the re-assessment record or in this review process that included dating and signing the initial assessment by way of evaluation.

A care plan primarily based on the activities of daily living was developed following admission based on the residents assessed needs in these areas. While some care plans were sufficiently detailed and had been updated with additional or changes in interventions, some care plans had not. For example, a resident identified with irregular clinical observations that required daily monitoring following a medical review did not have a care plan based on the assessed need and change in circumstances since admission. Some improvement was required to ensure each care plan was developed to contain sufficient information to specify the actual problem identified and guide the

necessary care interventions of residents to inform an evaluation.

Arrangements were in place to evaluate existing care plans routinely within a four monthly period. While the involvement of residents in planning care was reported, there was a lack of recorded evidence that residents and their families or carer's were actively involved or consulted with in relation to this process or central to clinical decisions made that affect them. Inspectors saw that staff had recorded in some care plans that the resident was unable to sign to demonstrate their involvement in the care plans.

Staff told inspectors they provided end-of-life care to residents with the support of their GP and community palliative care services. An end-of-life assessment record for some residents was available. However, improvements were required in relation to the overall assessment, planning and recording of end-of-life care. There was a lack of recorded evidence available to demonstrate that the family or carer of a resident was involved where appropriate in end-of-life decisions where a resident was assessed to have significant cognitive impairment. An advanced care directive by a GP for one resident seen on file had been communicated by a fax. There was no evidence of a consensual decision or agreement by all those involved in the care and treatment of the resident. An end-of-life care plan that outlined the physical, psychological and spiritual needs of the residents, including residents' preferences regarding their preferred setting for delivery of care had not been completed with all residents and or family.

Inspectors were told that a choice of a single room or alternative arrangements for residents in shared bedrooms was to be determined when residents were approaching their end of life. Relatives or friends could be accommodated in the first floor sitting room with refreshments made available. Staff outlined how religious and cultural practices, including religious services, were facilitated within the centre.

Inspectors were informed that none of the residents had pressure ulcers or wounds. Residents identified at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions.

Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Inspectors were told that residents had been administered subcutaneous fluids to treat dehydration in the past. The inspectors confirmed that one resident had a percutaneous endoscopic gastrostomy (PEG) tube in place and had been tolerating food orally with support and monitoring by staff and advise from allied health care professionals.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Referrals for review by a dietician and or speech and language therapist were prompted following assessment and monitoring reviews. Nutritional and fluid intake records when required were appropriately maintained in the sample reviewed. Procedures and care plans were in place in relation to nutritional care.

Inspectors saw that a choice of meals was offered and available to residents. A

communication aid with pictures of food items and drinks was seen available to residents in their bedroom and in the dining room. There was a system of communication between nursing and catering staff to support residents with special dietary requirements. Mealtimes in the dining rooms were social occasions with attractive table settings and staff sat with residents while providing encouragement or assistance with the meal. Some residents choose to dine in other areas and in their own bedroom, and this was facilitated.

There were arrangements in place to record and review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. A system was in place to highlight and communicate the risk rate to all staff. In the sample of care plans reviewed inspectors noted that the assessed falls risk had been recorded and reviewed where necessary following a fall. Additional interventions such as hip protectors, mats and sensory devices were made available to reduce the risk of falls and serious injury.

Residents had access to a pharmacist and general practitioner (GP) of their choice and the majority opted for the services of their previous GP. There were over four GP's attending to residents in the centre.

Arrangements were described that involved the residents GP, pharmacist and nursing staff in medicine management and review. However, a sufficient record of on-going medical assessment, treatment and care provided by a person's medical practitioner was not consistently available and improvement in the overall management of medicines was required.

There were written operational policies relating to the ordering, transcribing, prescribing, storing and administration of medicines to residents. The centre's policy documents dated 7 November 2011 were recorded as reviewed in January 2016. However, these policy documents had not been implemented and inspectors found unsafe practices in relation to the receipt, transcribing, prescribing, administration, recording and review of prescriptive medicines including controlled drugs.

Residents were not sufficiently protected by medicine management practices found during this inspection and the standards did not meet with professional or regulatory requirements as follows:
• medicines were administered to residents without a record, fax or copy of a prescription
• medicines had been administered to residents without recorded evidence that they had been prescribed by an authorised person or prescriber
• medicines had not been administered in accordance with the directions of a prescriber. Medicine prescribed 6 march for two weeks continued to be administered 28 March
• medicine dosages prescribed by an authorised person had been subsequently altered and or increased by an unknown person in the absence of a prescription
• a resident with a fax prescription that was altered had a record as 'oversedated'
• prescription and controlled medicines received by nurses on admission of residents from home did not have supporting or recorded evidence that the medicines were current prescribed treatments or in accordance with the directions of the prescriber
• medicines transcribed on a resident's kardex as commenced in September 2016 had not been signed by the GP or by an authorised prescriber and had been administered

• the medicine transcribing policy that included verification of medicines transcribed by a nurse to be checked by a second nurse was not consistently completed in practice
• the medicine policies included the requirement of an original prescription by a residents medical practitioner within 72 hours for fax or transcribed medicines which was not adhered to or seen implemented in practice
• the medicine policies stated that medicine prescriptions should be 'signed in ink by the prescriber' however medicines were administered from nurse records and fax copies including those dated December 2016, January and February 2017
• medicines were numbered in ink on fax prescriptions and had been subject to alterations and discontinued with a line drawn over the fax copy by an unknown person. Some numbers had been allocated to more than one medicine and to discontinued medicines making it unclear as to the duration and exact medicine administered
• controlled and high risk medicines were received and recorded as administered from a transcribed record in the absence of a prescription from a resident's medical practitioner (GP)
• a register and record of controlled drug checks was maintained by two nurses at the beginning and end of each shift, however, the recorded stock balance of one medicine subject to daily checks did match the amount found available in storage
• details of any plan relating to the resident in respect of medication on admission was not consistently available
• a photograph for each resident was not seen available with medicine or prescription records reviewed which may compromise resident safety
• a care plan to include all recommended treatments or medical reviews and or medicine adjustments was not developed or maintained to safeguard residents.

Inspectors confirmed that there were no nurse prescribers working in the centre, however, medicines had been recorded and confirmed by staff as administered in the absence of a record of a GP review and prescription. Inspectors concluded that nursing practice and records were not sufficiently maintained in accordance with the professional standards and guidelines issued by An Bord Altranais agus Cnáimhseachais (NMBI).

Overall, the systems and arrangements to provide appropriate medical and healthcare to residents and prospective residents required significant improvement. As a result on these findings a major non-compliance judgement was communicated to the provider and person in charge on the day of inspection that were required to take immediate action to address the seriousness of the findings. Written assurances were subsequently sought by HIQA within an immediate action plan issued and returned by 4pm on 31 March 2017.

Judgment:
Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

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

Findings:
This outcome sets out the inspection findings relating to the management of resident protection and how the centre responds and manages behaviour that challenges. The self assessment tool (SAT) completed by the provider was rated compliant in this outcome.

The centre had policies in place to protect residents from suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Staff had received training on identifying and responding to elder abuse. Staff were able to explain the different categories of abuse and had knowledge of what their responsibility is should they suspect abuse. In addition staff spoken to were clear about who they would report any concerns too.

The centre has a policy on and procedures in place to support staff to working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice and implemented by staff. Staff spoken with adopted a positive, person centred approach towards the management of behaviours that challenge. The person in charge informed inspectors that among the current residents only one resident displayed behaviour that challenges. Staff spoken with by inspectors were knowledgeable on the resident's triggers and were able to voice the appropriate intervention management. During the inspection it was observed that staff approached this resident in a sensitive and appropriate manner and the resident responded positively to staff.

The centre promoted a restraint free environment. The documentation on the management of restraint was discussed at the last inspection. The centre used the HSE management of restraint as their in house policy. This was discussed with the registered provider and the person in charge. They agreed to review and make improvements as required for the policy to guide staff on the management of restraint specific to this centre. Additional equipment to reduce the use of restraint such as low level beds, bed bumpers/wedges, and sensor alarms were available following an assessment and seen in use. The inspectors reviewed the care plan of one resident currently using bedrails and a lap belt. The care plan guided practice. The resident had a bedrails risk assessment and also had a falls risk assessment. There was evidence that all other measures had been exhausted and this was documented. This care plan was reviewed at required intervals. Safety checks were discussed at the last inspection and further improvement was required as the two hourly checks required were not consistently carried out or recorded consistently in the file reviewed. This was highlighted to the person in charge who was to discuss the gaps with all staff and highlight the importance of same.

The inspectors spoke with staff on how residents' funds were managed. As per the regulations there were systems in place to safeguard residents’ money. The centre was a pension agent for three residents'. There were clear procedures and practices in place to keep residents’ money safe.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Within the centre there was evidence that residents are consulted with and participate in the organisation of the centre. Each resident's privacy was observed to be respected. As per the regulations the registered provider had provided facilities for occupation and recreation. Residents can receive visitors in private outside of the main living areas. Resident forum meetings were held every two months within the centre. Minutes of these meetings were available and reviewed by the inspectors. There was clear evidence that the residents openly engage in the meetings. For example, one resident expressed a fear of being evacuated using an EVAC sheet in the event of a fire. To address this the staff carried out a simulation with the resident observing the evacuation procedure.

The centre had carried out resident and relative satisfaction surveys. The results of satisfaction surveys were analysed by the registered provider and changes were implemented as a direct result. For example, some residents had requested the option of a fry for breakfast and this was now in place and provided on request.

Within the centre the residents had access to an independent advocacy service and also SAGE services. Contact details of these services were strategically placed throughout the centre. Residents had access to local and national newspapers. There was a telephone for residents to use in private. Within the living area there was a notice board that had information on all local news that was happening or planned within the community. All residents within the centre had the option to exercise their right to vote. Religious services were provided for and relatives were welcome to attend.

Residents' privacy was observed to be respected by all members of staff. Staff were observed to knock on the door of all residents' private bedrooms and waited for a reply before entering. All residents had a locked drawer in their bedrooms. The inspectors observed the staff offered each resident the choice of meals and beverages. The inspectors observed resident and staff engagement at intervals throughout the day and overall the interactions were very positive.

The activities programme within the centre was resident focused with the residents consulted on a daily basis to decide what activity should be undertaken. On the day of inspection the inspectors observed that all clinical staff partook in the activities. There was active engagement between staff and residents. Within the day space and

communal areas there was multiple photographs of residents and staff partaking in special events. From a review of the minutes of residents meetings, there was evidence that residents were consulted with and involved in the plan of all special occasions.

Resident with communication difficulties were accommodated within the centre. The centre utilises communication boards to aid and support residents needs.

There was a good relationship between staff and residents in the centre, and visitors were greeted in a welcoming manner. Overall, a culture of person-centred care was evident and staff worked to ensure that each resident received care in a dignified way that respected their privacy. It was clear that staff knew the residents well, including their backgrounds and personal history. A 'getting to know me' record was seen completed in files reviewed that included stories and comments on each residents life, significant people and events.

The centre had a policy on residents' personal property and possessions. There was a record kept of each residents property in their file. Personal property was safeguarded through appropriate record keeping and secure storage arrangements.

The centre had a laundry service and there was suitable arrangements in place to ensure that residents own clothes were laundered and returned to them. Each resident had a wardrobe space and a locked drawer in their private bedroom.

Hairdressing arrangements were available on a weekly basis to support residents personal grooming.

There were many visitors in the centre on the day of this inspection and there were a number of areas where residents could meet with visitors in private. Family members told inspectors they were welcomed and had an opportunity to speak with staff when visiting. A record of visitors to the designated centre was available and maintained.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
This outcome sets out the inspection findings relating to the management of complaints. The self assessment tool (SAT) completed by the provider was rated compliant in this outcome.

There were policies and procedures for the management of complaints. The complaints

process was displayed in a prominent place in the reception area. The registered provider and the person in charge were both involved in the management of all complaints received depending on the nature of the complaint. The inspectors reviewed the complaints log. Records indicated that complaints were minimal, a total of four to date in 2017. Residents were informed on admission of the complaints procedure and his was evidenced within the files.

The management of all complaints received had been investigated promptly, a record of the outcome was documented and there was also detail if the complainant was satisfied with the outcome. The centre had an appeals officer and also directed the complainant to the office of the Ombudsman if unhappy with the outcome. The inspectors also saw evidence of improvements for residents as a result of complaints.

However the centre did not have a nominated person who reviewed and maintained the records with regards to all complaints. This was discussed with the registered provider and person in charge on the day of inspection and they agreed to review this requirement.

Residents spoken with on the day told inspectors that they would not hesitate to make a complaint if they had one. Relatives said that they were satisfied with the care and were aware of who they could complain to if they needed to.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
This outcome sets out the inspection findings relating to appropriate staff numbers and skill mix to meet the needs of residents, in a person centred way. The inspectors examined the training and development of staff to meet the needs of residents with dementia. The self assessment tool (SAT) completed by the provider was rated compliant in this outcome.

On the day of inspection there was sufficient staff to meet the assessed needs of residents. However there are no contingencies in place to cover planned and unplanned leave or to facilitate management time for the person in charge's role, monitor and observe staff in practice. Inspectors reviewed the rosters and identified that there was no allocated nurse to work one night duty in the current scheduled week. The person in charge told inspectors that the centre had at least one nurse on duty at all times as required by the regulations. The person in charge works full time but when on duty was

the only nurse rostered on. This was discussed in detail with the registered provider and the person in charge and is reported under Outcome 8.

The person in charge had no allocated protected time to carry out management responsibilities and duties such as pre admission assessments, in house audits and staff appraisals to ensure the effective delivery of care. The supervision arrangements for nurses was limited resulting in poor quality outcomes and poor standards in practice or accountability, as discussed in Outcome 1.

Some staff but not all received supervision. Inspectors reviewed the files of four staff. Documented evidence showed that all staff had a yearly appraisal. Each file contained the documents required under Schedule 2 of the regulations.

Staff had access to appropriate training. Of the files viewed there was documented evidence that all staff have been updated on manual handling training, elder abuse training and fire training. In addition to mandatory training, relevant training on basic life support, dysphagia and infection control management was provided. The centre recently had fourteen staff attend training on the management of challenging behaviour and the registered provider had plans for more staff to attend training courses.

Evidence of professional registration for all rostered nurses was available and current.

The centre had one volunteer. Their file contained a national vetting disclosure and a document outlining their role and responsibility, as required.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

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:
The self assessment tool (SAT) was rated substantially compliant in this outcome. The action plan response included improvements in relation to the rear internal garden and courtyard area by May 2017.

The centre did not have a separate dementia specific unit and residents with dementia integrated with the other residents in the centre.

The centre was found to be reasonably well maintained, warm, comfortably and visually

clean. Heat, lighting and ventilation were adequate and the temperature of the building met requirements in bedrooms and communal areas where residents sat during the day.

The premises had directional and visible signage and their previous house address on doors, and the colour scheme and the provision of calendars and clocks seen in resident's bedrooms promoted orientation and way finding.

The communal areas such as the dining room and the day room had a variety of comfortable furnishings and were domestic in nature. Side tables were available in communal sitting rooms to support residents with newspapers, tea cups, snacks and drinks.
Residents were accommodated on two floors. A passenger lift and stairlift was in place to support residents move between floors. However, the use of both required the support of staff and independent use of the lift was restricted by an apparatus fixed to the exterior door that prevented free access. These arrangements were known by residents spoken with that were accommodated on the first floor and seen advertised in a memo on the lift door for visitor's attention.

Parts of the centre included shared bedroom and bathroom accommodation. Residents' accommodation was in 10 single, six twin and two three bedded bedrooms. Since the last inspection, one multi occupancy bedroom had reduced from four to a three bedded room, one three bedded room had reduced to a twin room and a twin room had reduced occupancy as a single room. The overall maximum capacity had reduced from 29 to 26 residents, with 24 residents accommodated on the day of inspection.

The personal and communal space in bedrooms was enhanced as result of the reduced occupancy and there was no infringement on privacy and dignity found on this inspection as a result of the room size and layout.

Inspectors were told that residents were encouraged to personalise their rooms. Some rooms had personal photographs, memory boards and mementoes, although other rooms did not. Televisions, radio, communication and information notice boards were available throughout the centre. Great views and prompts to explore the surrounding countryside via binoculars from the sitting room of the first floor were promoted. Pictures and posters of various types of birds and trees had been created to facilitate engagement and exploration.

An ongoing maintenance programme was described. The identification and replacement of worn furniture and repair of damaged paintwork was ongoing. Calls bells were provided in resident bedrooms and staff confirmed that there was a sufficient supply of assistive equipment such as hoists, specialised beds and mattresses to meet residents' needs.

Parts of the centre and along some main corridors had strong contrasting colours. Hand rails along corridors, hoists, aids and supports in toilets and bathroom were provided to promote independence. Communal toilets were easily identifiable by colour and signage. The colour of the toilet seat and rail contrasted from the sanitary furniture in communal toilets.

Walkways were clear and uncluttered to ensure resident safety when mobilising. While there were no incidents involving the rail from the stairlift that extended into the ground floor corridor, inspectors recommended a risk assessment be completed.
The centre had windows that optimised natural lighting and view in most parts. However, the natural light and view from three bedrooms located on the ground floor within the internal building depended on natural light from the corridor and conservatory area where other residents and visitors occupied. Therefore, their view or outlook from their bedroom was limited but did not pose a problem for the current residents accommodated within.

A smoking room was not provided within the centre. Residents that smoked were seen supported by staff to leave the building to smoke outdoors in the porch area.

There were two outdoor areas for residents use. A sensory garden planted with herbs and decorated with attractive features and seating was well maintained. An internal courtyard that's ground or surface was to be upgraded by May 2017 was available to residents.

Relatives or friends had the use of facilities that included a resident's room, communal areas of first floor sitting room to meet in private.

The control of stimuli such as noise levels required improvement. During the feedback meeting the provider and person in charge were informed that a high level of noise from a bathroom door banging, call bells ringing and walking aid used by a resident was found at times throughout the inspection. They agreed to assess and review these matters.

Judgment:
Substantially Compliant

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The statement of purpose has been recently updated and the organisational structure was defined as required in the regulations.

The centre had a clearly defined management structure that identified the lines of authority and accountability. However, arrangements for the governance and management of the designated centre required improvement.

Management and staffing resources available did not ensure sufficient and effective

delivery of care required. On the day of the inspection the person in charge was working as the nurse responsible for the delivery of care. From a review of the roster it was apparent that this was a regular arrangement and the person in charge had no protected time built into her working week for management and governance responsibilities relevant to her role.

The whole time equivalent (WTE) and number of nurses outlined in the statement of purpose and available on the roster was not sufficient to ensure the effective delivery of care on a full time basis. Inspectors were told that the centre had an option of calling on relief nurses who had previously worked in the centre that were available at short notice. however, the service was also reliant on the person in charge working the nursing shifts and on overtime from nurses already working full time to maintain services during planned or unplanned leave periods or absences.

Inspectors concluded that the management arrangements required improvement and staffing resources available did not ensure that the service was consistently safe, appropriate and effectively monitored as required under the regulations.

There was evidence that the annual review required by the regulations was carried out in 2016. From a review of the report, there was evidence of consultation with residents and their representative. The outcome from residents and relatives satisfaction surveys was reflected in the annual report. The annual report also made reference to the in-house audits carried out that included audits from the pharmacy external service providers. However, based on the findings related to medicine management the systems and auditing arrangements in place were not sufficiently effective to ensure adherence with the approved policies or identify appropriate action to be taken to improve the service provision when necessary.

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:

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Willowbrook Lodge
Centre ID:	OSV-0000302
Date of inspection:	29/03/2017
Date of response:	21/04/2017

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policies relating to the ordering, transcribing, prescribing, storing and administration of medicines to residents had not been implemented consistently resulting in unsafe practices.

The policies relating to the admission of residents had not been implemented fully.

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

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

Please state the actions you have taken or are planning to take:
The current medication policy will be reviewed and amended to ensure that it accurately reflects the most current NMBI guidelines.

Once the policy has been developed and ratified it will be disseminated to all staff nurses. This will include in-house training on understanding and implementing the policy in its entirety.

To ensure that the policy is fully implemented in practice, monthly audits will be carried out with the PIC and ADON. This audit will include a complete review of current medication charts, will identify any non-compliances and will include action plans to address these.

To ensure that policies and procedures are implemented and practice is safe the Registered Provider has arranged for the Pharmacist to carry our clinical audit on residents and residents' medication on a monthly basis.

To ensure safer practice in future all nursing staff will have medication competency assessments completed on induction, annually and following any medication error or incident. All nursing staff will complete the HSELand medication management training and the Pharmacist will also provide on-site training to nursing and care staff.

The Admissions Policy will be reviewed and amended to ensure that it very clearly sets out what the centre's practices will be in terms of admission times, medication reconciliation, obtaining medical history and information etc. This policy will also reflect the guidelines issued by the Authority in May 2014: "Guidance for health and social care providers - Principles of good practice in medication reconciliation". Once the policy has been developed and ratified it will be implemented in its entirety. To ensure that the policy is fully implemented the PIC and ADON will include in any medication audits, all new admissions including long stay, respite and emergency. The PIC will develop a new admission criteria checklist which will include medication reconciliation and she will monitor that these are completed and that all the information as needed is available within 72 hours of admission.

Proposed Timescale:

Medication policy to be complete – 21st May 2017. To be implemented in practice – 31st May 2017.

First medication audit to be completed – 20th April 2017 and monthly thereafter.

Pharmacy clinical audit – 15th of May 2017 and monthly thereafter.

Medication competency assessments – on induction, annually (by 30th June 2017) and

following medication error.

HSELand medication management training for nurses – Immediate Effect.

Admission policy to be complete – 14th June 2017.

Admission checklist to be complete – 14th June 2017.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of recorded evidence that residents and their families or carer's were actively involved or consulted with in relation to this process or central to clinical decisions made that affect them.

2. Action Required:
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

Please state the actions you have taken or are planning to take:
A document which reflects the consultation with residents and/or families with regards care plan reviews, changes in care needs etc. has been developed and will be implemented immediately.

The care plan reviews are due at this time and the changes above will be implemented now.

Proposed Timescale:
Development of consultation record – complete.

Four monthly reviews to be complete – 30th April 2017.

Proposed Timescale: 30/04/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The initial care assessment was subject to regular reviews; however, changes evident since the initial assessment were not sufficiently reflected within the re-assessment care

record or in this review process that included dating and signing the initial assessment by way of evaluation.

3. 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:
The current care plan assessment system has been reviewed and moving forward a comprehensive assessment of the residents' activities of daily living will be completed every four months or more frequently if there is a change to status. The reassessment care records will no longer be used. This should ensure that each residents' care plan is a contemporaneous record of their current status and needs.

A document which reflects the consultation with residents and/or families with regards care plan reviews, changes in care needs etc. has been developed and will be implemented immediately.

The care plan reviews are due at this time and the changes above will be implemented now.

Proposed Timescale:
Change to the care plan assessment system – complete.

Development of consultation record – complete.

Four monthly reviews to be complete – 30th April 2017.

Proposed Timescale: 30/04/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some care plans were not put in place or sufficiently detailed and updated with interventions following a review or change in circumstances since admission.

Some improvement was required to ensure each care plan was developed to contain sufficient information to specify the actual problem identified and guide the necessary care interventions of residents to inform an evaluation.

4. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
To ensure that each care plan and care needs are contemporaneous records and show residents' current status and reflect changes in their circumstances and needs nursing staff will attend a care plan meeting where care planning and accountability will be discussed. The PIC recognises that care plans should be updated on an ongoing basis and not only during the four-monthly review. In order to ensure that changes are accurately reflected the PIC will be implementing a system whereby any changes to residents' status, medical condition are documented and she will be reviewing this on a weekly basis and checking that the care plans have been amended accordingly.

Proposed Timescale:

Nurses' care plan meeting – 18th April 2017 and changes to be implemented immediately following this.

Proposed Timescale: 18/04/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Medicine management practices and standards were not in accordance with the professional standards and guidelines issued by An Bord Altranais agus Cnáimhseachais (NMBI).

5. 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:
The current medication policy will be reviewed and amended to ensure that it accurately reflects the most current NMBI guidelines.

Once the policy has been developed and ratified it will be disseminated to all staff nurses. This will include in-house training on understanding and implementing the policy in its entirety.

To ensure that the policy is fully implemented in practice, the PIC will introduce a system of monthly monitoring of all medication charts to ensure that the medication chart, the administration sheet and the medication dispensed from the pharmacy are correct. This audit will include a complete review of current medication charts, will identify any non-compliances and will include action plans to address these.

To ensure that policies and procedures are implemented and practice is safe the Registered Provider has arranged for the Pharmacist to carry our clinical audit on

residents and residents' medication on a monthly basis.

To ensure safer practice in future all nursing staff will have medication competency assessments completed on induction, annually and following any medication error or incident. All nursing staff will complete the HSELand medication management training and the Pharmacist will also provide on-site training to nursing and care staff.

Proposed Timescale:

Medication policy to be complete – 21st May 2017. To be implemented in practice – 31st May 2017.

First medication audit to be completed – 20th April 2017 and monthly thereafter.

Pharmacy clinical audit – 15th of May 2017 and monthly thereafter.

Medication competency assessments – on induction, annually (by 30th June 2017) and following medication error.

HSELand medication management training for nurses – Immediate Effect.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Access to a medical practitioner or GP were not sufficiently adequate or timely to ensure appropriate medical care was consistently provided to residents and as a result, unsafe medicine management practices were found.

6. 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:
Medical reviews and GP visits are always requested where a need is identified, however, GPs may not always record the visit in the residents' medical notes in the nursing home (this may be due to time constraints or keeping records in their own surgeries). However, GPs and medical practitioners do see all residents on a regular basis. Moving forward the PIC will maintain a record of GP reviews and will ensure that the GPs are notified when three monthly reviews are due and will maintain a record of this notification. The PIC has reviewed all of the medical notes and has identified which residents are due a medical review and has highlighted this to the relevant GPs.

The PIC will develop a document to record of GP and medical practitioner visits which will be maintained in the care plans which will provide further evidence of GP reviews and will be easily retrievable.

The RP will write to the attending GPs and Care Doc Manager asking that they please make entries in the residents' medical notes during visits to Willowbrook.

Proposed Timescale:

Record of three monthly reviews due – complete.

Develop record of GP visits – 21st April 2017.

Letter to GPs and Care Doc Manager – 30th April 2017.

Proposed Timescale: 30/04/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of recorded evidence available to demonstrate that the family or carer of a resident was involved where appropriate in end-of-life decisions where a resident was assessed to have significant cognitive impairment.

7. Action Required:
Under Regulation 13(1)(c) you are required to: Inform the family and friends of the resident approaching end of life of the resident's condition, with the resident's consent. Permit them to be with the resident and provide suitable facilities for them.

Please state the actions you have taken or are planning to take:
The PIC does ensure (with residents' permission) that families and friends are notified as residents approach the end of their life and they are always facilitated to be with the resident if they so wish.

The PIC will ensure that a written record is maintained of all discussions regarding end of life care and advanced care directive decisions and is currently reviewing the Irish Hospice Foundation's "Thinking Ahead" document and will consider with the residents whether this is a tool that they would be satisfied to use.

Proposed Timescale:

"Thinking Ahead" document review - 30th April 2017.

Maintaining written records – immediate and ongoing.

Proposed Timescale: 30/04/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the overall assessment, planning and recording of end-of-life care.

An end-of-life care plan that outlined the physical, psychological and spiritual needs of the residents, including residents' preferences regarding their preferred setting for delivery of care had not been completed with all residents and or family.

An advanced care directive by a GP for one resident seen on file had been communicated by a fax. There was no evidence of a consensual decision or agreement by all those involved in the care and treatment of the resident.

8. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
The end of life care plans will be completed with all residents who wish to partake and the PIC will ensure that where a resident does not wish to discuss or have their wishes recorded, that this is documented. The PIC is very much aware that this can be a difficult subject for residents and families; however, she and the nursing staff are committed to offering each resident the opportunity to discuss this.

In reference to the advanced care directive above, there is a written record of a conversation had with the PIC and the resident and her son. There is also a written record from the resident's son which confirms that the conversation as to the resident's wishes for end of life care and advanced care directive, did take place. However, this document was not shown to the Inspector on the day of inspection. A copy of this record to be placed in the resident's care plan.

Proposed Timescale:

End of life care plans to be complete (for those residents wishing to partake) – 14th June 2017.

A copy of the records referred to above have now been placed in the resident's care plan – complete.

Proposed Timescale: 14/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure information from and liaison with the perspective resident's general practitioner (GP) or transferring hospital was obtained for planned or following emergency admissions (within 72 hours) in accordance with the centre's admission policy.

Inconsistencies in relation to the gathering of relevant information related to medicine prescribed and current treatment recommended was found.

A sufficient record of on-going medical assessment, treatment and care provided by a person's medical practitioner was not consistently available.

The most recent medical record for one resident was January 2016 and a subsequent communication in 2017 was issued by fax in relation to a significant decision.

An absence on-going assessment or review of some residents medical needs was found, where required.

9. 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:
The Admissions Policy is currently being reviewed and amended and while the PIC does request the information in relation medical history, medication etc. prior to admission, this is not always provided. However, in order to ensure compliance with statutory regulations the RP will not accept emergency admissions until the information has been provided.

The Admissions Policy will be reviewed and amended to ensure that it very clearly sets out what the centre's practices will be in terms of admission times, medication reconciliation, obtaining medical history and information etc. This policy will also reflect the guidelines issued by the Authority in May 2014: "Guidance for health and social care providers - Principles of good practice in medication reconciliation". Once the policy has been developed and ratified it will be implemented in its entirety. To ensure that the policy is fully implemented the PIC and ADON will include in any medication audits, all new admissions including long stay, respite and emergency. The PIC will develop a new admission criteria checklist which will include medication reconciliation and she will monitor that these are completed and that all the information as needed is available within 72 hours of admission.

Medical reviews and GP visits are always requested where a need is identified, however, GPs may not always record the visit in the residents' medical notes in the nursing home

(this may be due to time constraints or keeping records in their own surgeries). However, GPs and medical practitioners do see all residents on a regular basis. Moving forward the PIC will maintain a record of GP reviews and will ensure that the GPs are notified when three monthly reviews are due and will maintain a record of this notification. The PIC has reviewed all of the medical notes and has identified which residents are due a medical review and has highlighted this to the relevant GPs.

The PIC will develop a document to record of GP and medical practitioner visits which will be maintained in the care plans which will provide further evidence of GP reviews and will be easily retrievable.

The RP will write to the attending GPs and Care Doc Manager asking that they please make entries in the residents' medical notes during visits to Willowbrook.

In reference to the significant decision above, there is a written record of a conversation had with the PIC and the resident and her son. There is also a written record from the resident's son which confirms that the conversation as to the resident's wishes for end of life care and advanced care directive, did take place. However, this document was not shown to the Inspector on the day of inspection. A copy of this record to be placed in the resident's care plan.

Proposed Timescale:

Admission policy to be complete – 14th June 2017.

Admission checklist to be complete – 30th April 2017.

Record of three monthly reviews due – complete.

Develop record of GP visits – 21st April 2017.

Letter to GPs and Care Doc Manager – 30th April 2017.

A copy of the records referred to above have now been placed in the resident's care plan – complete.

Proposed Timescale: 14/06/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not sufficiently protected by medicine management practices found during this inspection and the standards did not meet with professional or regulatory requirements as follows:

• medicines were administered to residents without a record, fax or copy of a prescription
• medicines had been administered to residents without recorded evidence that they had been prescribed by an authorised person or prescriber
• medicines had not been administered in accordance with the directions of a prescriber. Medicine prescribed on 6 march 2017 for two weeks duration continued to be administered 28 March 2017
• medicine dosages prescribed by an authorised person had been subsequently altered and or increased by an unknown person in the absence of a prescription
• a resident with a fax prescription that was altered had a record as 'oversedated'
• prescription and controlled medicines received by nurses on admission of residents from home did not have supporting or recorded evidence that the medicines were current prescribed treatments or in accordance with the directions of the prescriber
• medicines transcribed on a resident's kardex as commenced in September 2016 had not been signed by the GP or by an authorised prescriber and had been administered
• the medicine transcribing policy that included verification of medicines transcribed by a nurse to be checked by a second nurse was not consistently completed in practice
• the medicine policies included the requirement of an original prescription by a residents medical practitioner within 72 hours for fax or transcribed medicines which was not adhered to or seen implemented in practice
• the medicine policies stated that medicine prescriptions should be 'signed in ink by the prescriber' however medicines were administered from nurse records and fax copies including those dated December 2016, January and February 2017
• medicines were numbered in ink on fax prescriptions and had been subject to alterations and discontinued with a line drawn over the fax copy by an unknown person. Some numbers had been allocated to more than one medicine and to discontinued medicines making it unclear as to the duration and exact medicine administered
• controlled and high risk medicines were received and recorded as administered from a transcribed record in the absence of a prescription from a resident's medical practitioner (GP)
• a register and record of controlled drug checks was maintained by two nurses at the beginning and end of each shift, however, the recorded stock balance of one medicine subject to daily checks did match the amount found available in storage
• details of any plan relating to the resident in respect of medication on admission was not consistently available
• a photograph for each resident was not seen available with medicine or prescription records reviewed which may compromise resident safety
• a care plan to include all recommended treatments or medical reviews and or medicine adjustments was not developed or maintained to safeguard residents.

10. 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:

(i) The Medication Policy is currently being reviewed to ensure that it meets all the

NMBI Medication Management guidelines “Guidance to Nurses and Midwives on Medication Management”.

(ii) Some of the practices above occurred because telephone orders from GPs were taken for changes to medication and these were not always followed up with a prescription or the Kardex was not subsequently signed by the GP. Moving forward, no telephone orders will be accepted for changes to medication regimes (only in the event of an emergency as prescribed by the NMBI guidelines).

(iii) Prior to any future admissions, a copy of the most recent prescription will be requested and no resident will be admitted until this information has been obtained.

(iv) The PIC and RP have spoken with the GP and asked that all Kardex be signed in ink and in their own hand writing and the PIC through regular audit will ensure that Kardex are not circulated or used until they are signed appropriately. All transcribing will be done in accordance with the NMBI guidelines and transcribed Kardex will be signed by the GP within 72 hours.

(v) The current medication Kardex and administration system has been reviewed. A new Kardex and administration sheet have been developed, which require that each medication administered be signed for individually. The Nurses are currently familiarising themselves with the new system which will be implemented on the next 28-day medication cycle.

(vi) The current system for recording stock balance of controlled drugs will continue as previous but the PIC will now monitor the recording on a weekly basis to ensure that the correct stock balance is recorded.

(vii) All residents will be (with their permission) photographed on admission and this task will be included in the newly developed admission checklist. The PIC has ensured that all the current residents have a photograph with their Kardex.

(viii) To ensure that each care plan and care needs are contemporaneous records and show residents’ current status and reflect changes in their circumstances and needs nursing staff will attend a care plan meeting where care planning and accountability will be discussed. The PIC recognises that care plans should be updated on an ongoing basis and not only during the four-monthly review. In order to ensure that changes are accurately reflected the PIC will be implementing a system whereby any changes to residents’ status, medical condition are documented and she will be reviewing this on a weekly basis and checking that the care plans have been amended accordingly. The PIC will ensure that care plans are audited every four months.

Proposed Timescale:
(i) 21st May 2017
(ii) Immediate
(iii) Immediate
(iv) Immediate
(v) At the beginning of the next medication cycle

(vi) Week commencing 17th April 2017
(vii) Admission checklist - 30th April 2017
(viii) Nurses' care plan meeting – 18th April 2017 and changes to be implemented immediately following this
(ix) Care plan audit to be complete by 30th June 2017

Proposed Timescale: 30/06/2017

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The was no centre specific policy on the management and use of restraint.

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

Please state the actions you have taken or are planning to take:
The Restraint Policy will be reviewed and amended to ensure that it is centre specific.

Proposed Timescale:

Policy to be reviewed and amended by 31st July 2017.

Proposed Timescale: 31/07/2017

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider shall ensure that there is a nominated person other that the person who complaints are managed by to ensure that all complaints are appropriately responded too and the required records are maintained.

12. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
The PIC is nominated person under Regulation 31(1)(c) and a Company Director has been appointed as the person referred to under Regulation 34(3). The Complaints Policy will be amended to reflect this.

Proposed Timescale:

Policy to be amended by 21st April 2017.

Proposed Timescale: 21/04/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number and skill mix of available staff was not appropriate at all times to meet the needs of residents.

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

Please state the actions you have taken or are planning to take:
There is a robust bank of Nurses who are available to work in the centre and do cover annual leave, unplanned absences etc. unless in an emergency situation, the permanent contracted nurses are not required to work beyond their contracted hours. As shown on page 14 of this report, it does state that there was sufficient staff on duty on the day of the inspection to meet the assessed needs of the residents and the RP is committed to maintaining these skill mixes and staffing levels.

The RP and the PIC have discussed the duties of a PIC and have agreed set management hours to enable the PIC to carry out her roles and responsibilities.

Proposed Timescale:
(i) Ongoing
(ii) PIC Management hours to commence immediately

Proposed Timescale:

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The identification and replacement of worn furniture and repair of damaged paintwork was on-going.

The internal courtyard's ground surface was to be upgraded by May 2017.

A high level of noise found from a bathroom door banging, call bells ringing and walking aid used by a resident at times throughout the inspection was to be assessed and reviewed.

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

Please state the actions you have taken or are planning to take:
(i) The centres programme for the replacement/repair of worn furniture and damaged paintwork is ongoing as identified above.

(ii) The internal courtyard's ground surface will be upgraded by May 2017 as identified above.

(iii) We have assessed, reviewed and adjusted the bathroom door so that it no longer bangs.

(iv) The walking aid has been assessed and a glider has been fitted to the aid.

(v) Call bells will continue to be answered in a timely fashion to ensure that they do not negatively impact on residents' welfare. The RP will add to the agenda of the Residents Committee meeting the item of noise levels, and should residents identify any concerns they will be addressed without delay. It is also imperative that the call bells can be heard and remains audible to staff to be answered in a timely fashion.

Proposed Timescale:
(i) Ongoing
(ii) May 2017
(iii) Complete
(iv) Complete
(v) Ongoing

Proposed Timescale: 31/05/2017

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management and staffing resources available did not ensure effective delivery of care and services required.

15. 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:
The Registered Provider is committed to providing all the resources necessary to ensure effective deliver of care. The RP and the PIC have discussed the roles and responsibilities of a PIC and have agreed set management hours to enable the PIC to carry out her duties, and the Registered Provider and Person in Charge will review this on a monthly basis.

There is a robust bank of Nurses who are available to work in the centre and do cover annual leave, unplanned absences etc. unless in an emergency situation, the full time contracted nurses are not required to work beyond their contracted hours. As shown on page 14 of this report, it does state that there was sufficient staff on duty on the day of the inspection to meet the assessed needs of the residents and the RP is committed to maintaining these skill mixes and staffing levels.

Proposed Timescale:

PIC management hours from 2nd May 2017.

Proposed Timescale: 02/05/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements for the governance and management of the designated centre required improvement.

This was a regular arrangement and the person in charge regularly works as a nurse and has no protected time built into her working week for management and governance responsibilities in this role.

The whole time equivalent (WTE) and number of nurses outlined in the statement of purpose and available on the roster was not sufficient to ensure the effective delivery of care on a full time basis.

The current service was reliant on the person in charge working the nursing shifts and it was reliant on overtime from nurses working full time or relief staff to maintain services during planned or unplanned leave or absences.

16. 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:
The RP works full-time in the centre and works closely with the PIC to support her in her role. The RP and PIC have discussed the governance and management of the centre and have agreed set management hours for the PIC. The RP and PIC will have a governance meeting which will include agenda items such as Governance, Finances (Accounts Matters), Equipment / Resources, Communication, Residents, Risk Management/ Health & Safety, Audits, Policies & Procedures, Staffing/ Staff Management, Training & Education, Infection Control, HIQA Matters, Staffing, Bed Occupancy/ Waiting List/ Pre-Admission, Complaints and Quality Improvement, Plan of Works.

There is a robust bank of Nurses who are available to work in the centre and do cover annual leave, unplanned absences etc. unless in an emergency situation, the permanent contracted nurses are not required to work beyond their contracted hours. As shown on page 14 of this report, it does state that there was sufficient staff on duty on the day of the inspection to meet the assessed needs of the residents and the RP is committed to maintaining these skill mixes and staffing levels. This bank of nurses have attended training, have Garda vetting disclosure, have full staff files that meet the requirements of Schedule 2 and are familiar with the centres policies and procedures and needs of the residents.

The full-time nurses are not required to work regular over-time and the RP and PIC will monitor staffing and staffing levels as part of the overall governance of the centre. Resident dependency levels are monitored on a monthly basis using a recognised assessment tool. The PIC will discuss with the RP should there be a requirement for additional care hours.

Proposed Timescale:

Formal governance meetings to commence – 21st April 2017.

Proposed Timescale: 21/04/2017