

**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:	Bishopswood, Dundrum, Tipperary.
Telephone number:	062 71 335
Email address:	paddy@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:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	40
Number of vacancies on the date of inspection:	3

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.

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 National Standards. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
15 November 2017 07:30	15 November 2017 17:30
16 November 2017 07:30	16 November 2017 15:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was a two day unannounced inspection by the Health Information and Quality Authority (HIQA). This unannounced inspection was conducted to follow up on non-compliances identified on a previous registration renewal inspection completed 13 December 2016 and to monitor ongoing compliance with the regulations and standards.

Woodlands Nursing Home is located in a rural setting approximately 1.5kms from Dundrum, Co Tipperary. The center can accommodate 43 residents and on the first day of this inspection there were 40 residents living in the center. There is a well established enclosed garden area available to residents to the rear of the center and a car park facility to the side of the main entrance.

As part of the inspection process, the inspector met with residents, visitors, staff members, the person in charge and the provider representative. The inspector observed practices and reviewed documentation such as policies and procedures,

care plans, medication management, staff records and accident/incident logs. A number of residents stated that they were happy with the care they received and felt safe living in the center. Visitors also confirmed that their loved one was well cared for and that staff were attentive to residents' needs. The inspector noted that staff spoken to knew residents well and were able to demonstrate a good knowledge of residents' healthcare and support needs.

From the eight actions identified in the previous inspection five had been completed however, three actions in relation to staff records, fire safety training and recording of complaints had not been sufficiently addressed and are therefore restated in this report.

There were 10 outcomes reviewed on this inspection and three were compliant, four outcomes were substantially compliant and three outcomes safeguarding and safety, health and safety and risk management and medication management were moderately non-compliant with the regulations. The action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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 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:

While some of the actions from the previous inspection had not been fully completed; overall there was evidence that the management team were generally effective in providing the care and support in this centre. This was evidenced by the level of compliance identified on the last inspection, the overall findings from this inspection and the on-going improvements within the centre. The provider representative was based on site and he was also a provider representative for another centre. The provider representative was supported in the administrative aspect of this role by a personal assistant.

Throughout this inspection the inspector spoke to both the provider representative and the person in charge. They explained their areas of responsibility and were found to be suitably knowledgeable and resident oriented, in their approach. They were aware of the regulations governing the sector and the national standards. Evidence of consultation with residents was clearly available in a sample of residents care plans and minutes of residents' meetings. The provider had regular meetings with the person in charge and an action plan for matters to be addressed in the centre was developed and regularly updated. They both lived in close proximity to the centre and were easily contactable out of hours to provide support, if required. The person in charge was an experienced nurse manager and had been appointed to this position for over ten years, having previously worked in the centre for many years. The person in charge was supported by the provider representative with daily informal meetings and regular structured management meetings and the provider representative stated that he was always available when required. The inspector noted that there was also an Assisted Director of Nursing (ACNO) available to support the person in charge in her role. The inspector met the ADON who had the relevant experience and qualifications for this role. The person in charge outlined how both the ADON and the person in charge worked a five day roster. The person in charge also outlined how the ACNO effectively supported the person in

charge in her role and meeting her responsibilities. Staff to whom the inspector spoke were familiar with the organisational structure of the centre. Overall the provider representative and person in charge had good oversight of the service. The person in charge informed the inspector that she had adequate autonomy and support to meet her responsibilities under regulation.

There was evidence of meetings with staff and regular meetings were held with residents. The person in charge was well known to residents and relatives to whom the inspector spoke with. From a review of the minutes of residents meetings it was clear that issues identified were addressed in a timely manner and that the person in charge was proactive in addressing any concerns or issues raised. For example, there had been queries regarding equipment in bedrooms, the selection of newspapers, the physiotherapy services and a suggestion about a new choice of activities was discussed. There was evidence that each of these residents' queries had been actioned and completed. Where areas for improvement were identified in the course of the inspection both the person in charge and the provider representative demonstrated a conscientious approach to addressing any issues and a commitment to compliance with the regulations. For example, the inspector requested that the person in charge to review the staffing arrangement during the hand over meeting on the morning of the first day of inspection. The inspector noted that the person in charge immediately made adjustments to the staffing arrangement during the hand over meeting that evening.

There was a annual report for the centre completed for 2016 and audits were made available to the inspector for 2017. Audits were completed in pertinent areas to review and monitor the quality and safety of care and the quality of life for residents. For example, such as falls prevention, pressure sore prevention, restraint, care plans and psychotropic medication use. The audits identified areas for improvement and audit recommendations. Improvements were brought about as a result of learning from these audits. For example, the findings from the audits had informed improvements in the care planning documentation particularly in response to incidents of falls and the use of restraint.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector interacted with the person in charge throughout the inspection process. The person in charge worked Monday to Friday from 09:00am to 17:00pm and lived in

close proximity to the centre. She outlined how she regularly visited the center out of hours and was on call out of hours. There was evidence that the person in charge was effectively engaged in the governance, operational management and administration of the centre on a day-to-day basis. The person in charge was an experienced nurse manager and had been appointed to this position for over ten years, having previously worked in the centre for many years. The person in charge possessed the clinical knowledge and experience of older person services to ensure suitable and safe care. During the inspection, the person in charge demonstrated good knowledge of the legislation and of her statutory responsibilities. She was clear in her role and responsibilities as person in charge and displayed a commitment towards providing a person centred quality service. The person in charge was supported in her role on a daily basis by the provider representative and the ADON. Residents and staff to whom the inspector spoke identified her as the person who had responsibility and accountability for the service. There was evidence that the person in charge had a commitment to her own continued professional development and had completed a number of courses such as care of the older person, tracheotomy care, dying and bereavement and a management course.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

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

Findings:

One action from the previous inspection regarding incomplete staff files as required under Schedule 2 of the Regulations continued to be non-compliant and is restated under this outcome. On this inspection one staff file that did not contain a record of the staff' employment history and another staff file contained only one reference instead of the minimum of two references as required by regulation.

Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were maintained and made available to the inspector. The inspector

reviewed a selection of the centre's operating policies and procedures and noted that the centre had site specific policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. These policies were reviewed and updated at intervals not exceeding three years as required by Regulation 4. There was evidence that there was on-going training to staff on policies and procedures and staff had signed off on these once they had received the training.

The inspector viewed the insurance policy and saw that the centre was insured against accidents or injury to residents, staff and visitors. Overall the inspector was satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

Judgment:

Substantially Compliant

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:

The inspector found that there were measures in place to protect residents from suffering harm or abuse. These included suitable policies and procedures in place to guide staff in the care and protection of residents. For example, there was a policy on safeguarding and elder abuse, a policy on behaviour management and a policy on protecting residents' privacy and dignity. Safeguarding training was also provided on an on-going basis in-house. From a review of the staff training records all staff had received up-to-date training in a programme specific to protection of older persons. This training was supported by the aforementioned policy document on elder abuse which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise. A number of staff, the ADON and the person in charge were interviewed and demonstrated a good understanding of safeguarding and elder abuse prevention. All were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident.

There was a policy on responsive behaviour (a term used to describe how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Most staff were provided or had been scheduled for training in responsive behaviors which was on-going. The inspector

noted that there were a small number of residents with a diagnosis of dementia living in the centre. A number of corridors in the centre had been recently repainted and the person in charge outlined how she was in the process of making improvements regarding supporting residents with dementia or a cognitive impairment. For example, the person in charge outlined plans for increase use of orientation aids such as additional clocks and calendars and improved signage to be provided throughout the centre. Training records showed that most staff had received up-to-date training in this area at the time of the inspection and the person in charge stated that further training in responsive behaviours was planned. There was evidence that for the residents who presented with responsive behaviour they were reviewed by their General Practitioner (GP) or other professionals for full review and follow up as required. Care plans reviewed for residents exhibiting responsive behaviour were seen to include positive behavioural strategies.

The inspector spoke to the person in charge and the provider representative in relation to the management of residents' finances and was satisfied that there were transparent systems in place for the management of residents' finances. These systems were guided by a centre specific policy. Comprehensive financial records that were easily retrievable were kept on site in respect to each resident. There was an itemised record of charges made to each resident, money received or deposited on behalf of the resident, monies used and the purpose for which the money was used was maintained. The provider representative confirmed that he acted as a pension agent for five residents. In relation to these pension accounts there were transparent arrangements in place to safeguard each residents' finances and financial transactions. However, the inspector noted that improvement was required with the creation of a residents' account separate from the center's in order to be fully compliant with the Department of Social Protection guidelines for pension agents.

Overall there was evidence of a restraint free environment was promoted in the centre. The person in charge stated that the centre was contentiously working towards this aim. This was evidenced from the inspector's observations, from speaking to staff and from a review of records including care plans and restraint register, assessments and monitoring records. There was a centre specific policy on restraint and the overall use of restraint was in line with national policy. The restraint register recorded 15 residents using bedrails on the days of inspection. The person in charge stated that a number of residents had requested bedrails to be placed on their beds. From a sample of residents' records there was evidence that residents' with any form of restraint had regular checking/monitoring in place, discussion with the resident's and/or their family and the GP. The inspector saw that there was an assessment in place for the use of bedrails or lap belts. These assessments clearly identified what alternatives had been tried to ensure that the particular form of restraint was the least restrictive method to use. There were also records available for all residents in relation to the trailing of alternatives. The inspector was assured by these practices and saw that whenever possible alternative measures were used. The centre was located adjacent to a busy road and the inspector observed that all exit doors in the centre were accessible via the use of digital coded locks. Residents and visitors could press a door bell/call bells or ask staff if they wished to use these doors. However, this environmental restraint had not been managed or recorded in line with national policy.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

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

Findings:

One action from the previous inspection in relation to staff having had up to date with fire safety training remained incomplete and is restated under this outcome. There was fire safety training provided by an outside fire safety instructor on two days during the week that this inspection was conducted. All staff spoken to demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The person in charge told the inspector and records confirmed that fire drills were undertaken regularly. However, one staff spoken to stated that they had not attended this training or had participated in a fire evacuation drill in the centre. The person in charge informed the inspector that they would ensure that all staff had such training as soon as possible and written confirmation was received by HIQA on 22 November that all staff have attended fire safety training and participated in a fire drill.

There were fire policies and procedures that were centre-specific. The fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. The inspector examined the fire safety register which detailed services and fire safety tests carried out. Fire fighting and safety equipment had been tested in September 2017, the fire alarm was last tested in November 2017 and the emergency lighting was last tested in August 2017. In addition, there were records of weekly fire alarm and emergency lighting and daily monitoring of fire exits. However, on the first morning of the inspection the inspector noted that there was a wedge in one of the entrance doors into the centre and the door into the smoking room was held open by a chair. The person in charge immediately removed both the door wedge and the chair from these doors.

The inspector noted that there was "an emergency box" stored in the nurse office that contained a number of pertinent emergency items including a torch, high visibility vest, the evacuation folder, the missing persons folder and the personal emergency evacuation plan (PEEP's). The person in charge outlined how these documents were made readily available to support staff in managing any emergency situation involving a resident in the centre. However, not all of the PEEP records viewed were adequate as two PEEP records were dated as completed in 2013 and may have required updating. In addition, the PEEP records did not contain details regarding the residents' level of

supervision when brought to a place of safety following evacuation.

There was a risk management policy as set out in schedule 5 of the regulations and included all of the requirements of regulation 26(1). The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. There was a risk register available in the centre which covered for example, risks such as residents' falls, fire safety risks and manual handling risks. There were adequate governance and supervision systems in place to monitor residents at risk of falls, wandering or negative interactions. These were reviewed by the person in charge on an ongoing basis. Overall the premises appeared safe and there were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on corridors and safe walkways were seen in the outside areas.

There was a centre specific safety statement and the inspector was informed that the provider representative and the person in charge met each month to review health and safety issues including any incidents, accidents or near misses in the centre. This meeting also reviewed procedures and practices including risk management and fire safety in the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency and assessments for pressure ulcer formation. All accidents and incidents were recorded in the computerized care planning system and submitted to the person in charge and provider representative. The inspector noted that there was evidence of suitable actions in response to individual incidents. For example, from a sample of records of incidents involving residents it was clearly recorded the action taken to support the resident following any untoward event. There was recorded information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning/changes required to prevent reoccurrence. There was also evidence of further actions including reviews of practice, care planning, updated risk assessments and further staff training. However, the hazard identification process required improvement as a number of potential hazards were identified by the inspector that required action including:

- the unrestricted access to one of the sluice rooms had not been risk assessed
- the suitability of the closing/locking mechanism of the treatment room door required review as this door was found unsecured on two occasions during the inspection
- the storage of lighters in some residents bedrooms required a risk assessment
- the smoking risk assessment record required review to clearly demonstrate the rationale for the quantification of identified risks
- the suitability of the two double doors into the main sitting/dinning room required review to facilitate residents with a reduced mobility access this room
- two chairs in the nurses office and one chair in the main sitting room were damaged and potentially hazardous
- the storage of latex gloves had not been risk assessed and were potentially hazardous to any resident with a cognitive impairment.

The inspector spoke to staff that worked in the laundry and the handling and segregation of laundry was generally in line with evidence based practice. Overall there were systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. Latex gloves were located throughout the centre and staff confirmed that they used personal protective equipment such as latex gloves as appropriate. All laundry was done in the center unless the

resident wished to send their laundry home. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and most staff that were interviewed demonstrated knowledge of the correct procedures to be followed. All staff interviewed were adequately knowledgeable in infection prevention and control or demonstrated suitable hand hygiene practices. The communal areas and bedrooms were found to be clean and there was good standard of general hygiene in the centre. However, there were a number of infection control issues including:

- the top of the dryer in the laundry room contained an excessive amount of dust
- the sink in one of the sluice rooms was not adequately clean on both days of the inspection
- there were no rack available for the storage of urinals in one sluice room
- there was a crack in some tiles in a communal shower/toilet room which would potentially impede effective cleaning
- the cleaning practices as described to the inspector in relation to the changing of the cleaning mop heads was not in keeping with best practices and prevention of cross contamination
- there was an uncovered waste bin in a communal shower/toilet room which may have been a hazard to residents with a cognitive impairment
- the extractor fan in the smokers room contained excessive dust
- there were two unclean hair brushes stored in a kidney dish on a laundry trolley in a bedroom corridor
- the fridge used to store residents' medications was not adequately clean and had visible stains on the door and bottom shelf of the fridge.

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:

There was a centre specific medication administration policy in place which was dated as most recently reviewed in June 2017. This policy had been made available to all nursing staff who had signed to confirm that they had read and understood its' contents. There had been audits completed in relation to the use of psychotropic medication and the audit results were regularly reviewed by the person in charge. Medication management training had been provided to all nursing staff. There was a community retail pharmacist who supplied medication to the centre. Nursing staff with which the inspector spoke demonstrated adequate knowledge of the general principles and responsibilities of medication management. Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Staff informed the

inspector that there were no residents currently self-medicating in the centre.

Nursing staff with whom the inspector met outlined an adequate procedure for the ordering and receipt of medicines in a timely fashion. There was a medication fridge located in the clinic room which was locked and only accessible by nursing staff. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. There was also a cleaning schedule/record available for the medication refrigerator. However, as identified and actioned under outcome 8 of this report, the medication fridge was not adequately clean.

Medications requiring additional controls under the Misuse of Drugs Regulations were seen to be suitably stored. Generally there were adequate systems in place for the handling and storage of controlled drugs in accordance with current guidelines and legislation including the Misuse of Drugs Regulations. One of the requirements for controlled medications was for the stock balance to be checked and signed for by two nurses at the end of each shift. Each balance check was recorded in a controlled drugs stock balance record. However, from a review of this record the inspector noted five occasions since June 2017 when one of the nurses signature was not recorded. In addition, on one of these dates both nurses' signatures were noted to be absent from this record.

Medication administration was observed at lunch time on the first day of inspection. The inspector found that the nursing staff adopted a person-centred approach and a sample of medication prescription records was reviewed. Overall medicines were seen to be administered in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais. Compliance aids were used by nursing staff to administer medicines. A sample of medication prescription records was reviewed. The practice of transcription was generally in line with the center-specific policy and guidance issued by An Bord Altranais agus Cnáimhseachais for all prescriptions seen. From a sample of medication administration records reviewed, the inspector noted that prescription records recorded the details of medications such as the dosage and time of administration as prescribed by GP's. However, one prescription record did not have any date recorded for when this medication had been prescribed and therefore this record did not provide an accurate medication record or medication prescription history.

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):

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

Findings:

On the previous inspection improvements were 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 and to inform an evaluation. On this inspection, the inspector noted from a sample of care plans reviewed that each residents' care plan and care needs were contemporaneously recorded and reflected changes in their circumstances and identified health and social care needs. The person in charge stated that she was supported by the ADON in ensuring that nursing staff were clinically accountable for individually named residents care and that support needs were being met. The person in charge informed the inspector that she monitored and reviewed residents care plans on a weekly basis or more often if required. From a review of a sample of residents care plans, the inspector noted evidence that all care plans and care plan assessment were up to date as required.

Overall the inspector was satisfied that residents' healthcare requirements were met to an adequate standard. There was a centre specific admissions' policy and the person in charge completed a pre-admission assessment on all prospective residents prior to their admission. Care plans were audited in the centre with the most recent audit completed in July 2017. Assessments and care plans were reviewed four-monthly or more frequently as required. A daily nursing record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. Overall there were adequate systems in place for the assessment, planning, implementation and review of healthcare needs. Based on a random sample of care plans reviewed; overall the inspector were satisfied that the care plans reflected the resident's assessed needs, assessment was supported by a number of evidenced-based assessment tools and plans of care to meet most identified needs. There were assessments of residents overall health and social care needs on admission and on readmission following return from acute hospital care and as required for example, when clinical deterioration was noted. The inspector saw that residents had a comprehensive nursing assessment completed following admission. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. There was evidence of regular GP reviews from the sample of residents' records reviewed and on the second day of the inspection the inspector met one of the visiting GP's. There was evidence of access to specialist and allied healthcare services to meet the care needs of residents. For example, speech and language therapist (SALT), psychiatry, opticians, dentists and chiropody services. Access to palliative care specialists, dietician and physiotherapy were also available. On the second day of inspection the inspector met a member of the community palliative care team who was visiting one of the residents. Systems were in place for the on going assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. The center had a computerized care planning system in place and from a review of care plans there were

adequate details to support staff in effectively managing residents' health problems.

There was evidence that the person in charge monitored the care planning system to ensure that residents' support and care needs were met. For example, staff nurses and care staff attended the handover meetings, the person in charge, ADON and staff nurses liaised with GP's and allied healthcare professionals and regularly reviewed care plans to ensure appropriate care provision. The inspector found that the care plans were person centred and individualised. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs. The inspector attended the morning hand over meeting on the first morning the inspection. The inspector noted that the staff nurse on night duty gave feedback on all residents care and support needs from the previous night to incoming day shift staff nurses and care staff. However, a number of day staff were observed leaving this meeting to attend call bells and therefore did not hear the full details of the handover. The inspector requested the person in charge to review this arrangement to ensure that all staff could attend the full hand over meeting. The person in charge informed the inspector that she had reviewed the staffing arrangements to ensure that all staff could attend the morning and evening handover meetings without any interruption. The inspector again attended the morning hand over meeting on the second day of inspection and noted that all staff could attend this meeting without any interruption.

The inspector noted that there were a number of residents who required Percutaneous Endoscopic Gastrostomy Feeding (PEG) and there was adequate care plans in place to guide nursing and healthcare staff practice. Staff spoken to confirmed that they monitored residents when receiving PEG feeds and there were monitored records maintained.

There was evidence of active falls prevention in the centre. For example, falls were monitored and audited closely with the most recent audit completed October 2017. All residents had been risk assessed in relation to their risk from falls. The level of falls in the centre was reviewed regularly by the person in charge and staff at regular care staff meetings to promote the reduction in the incidence of falls within the centre. This meeting also reviewed any other such incidences of slips, trips or near misses in the centre. All incidences of falls were reviewed individually to identify any possible antecedents or changes/learning that could be obtained to prevent any re-occurrence. Subsequently, measures were identified in residents' falls prevention care plans and there were also reassessments of falls risks by staff after each fall. The inspector was satisfied that overall care plans contained few identified deficits between planned and delivered care. Residents and their representatives to whom the inspector spoke were complementary of the care, compassion and consideration afforded to them by staff.

Judgment:
Substantially Compliant

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):

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

Findings:

Most of the actions from the previous inspection had been completed. There was a person nominated to oversee that all complaints were appropriately responded to and adequate records were in place. On review of the complaints log there was evidence that some complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcome of their complaint and records evidenced whether or not they were satisfied. However, as identified on the previous inspection, the level of complaints recorded was low. The person in charge acknowledged that not all complaints that were resolved locally may have been documented in line with the centre's policy and as required by regulation. The inspector noted that the person in charge had previously raised this issue at recent staff meetings.

Overall policies and procedures which complied with legislative requirements were in place for the management of complaints with the centre specific complaints policy reviewed in May 2017. There was an independent appeals process and complaints could be made to any member of staff. The person in charge was the designated complaints officer. Residents and their representatives were aware of the complaints' process which was on public display near the entrance to the centre.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

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

Findings:

There was evidence that residents were consulted with and participated in the organisation of the centre. Overall, residents' rights, privacy and dignity were respected, during personal care, when delivered in their own bedroom or in bathrooms. Residents spoken with confirmed that they were afforded choice in relation their daily lives and for

example receive visitors in private. There were no restrictions to visiting in the centre and the inspector observed several visitors at different times throughout the two day inspection. There was a visitor's record book available near the entrance to the centre and the inspector noted that some but not all visitors had signed this record. The person in charge agreed to review the arrangements to encourage more visitors to sign the visitors' record.

Residents' right to choice, and control over their daily life was also facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Evidence that residents and relatives were involved and included in decisions about the life in the centre was viewed. Regular meetings were held where residents were consulted through the residents' committee meetings. The most recent residents' committee meeting was recorded as occurring in September 2017. The inspector noted a high number of residents attended this meeting. The activities coordinator chaired this meeting and she outlined that the role of this meeting was to ensure that residents' actively participated in decision making and to provide and receive feedback in relation to life in the centre. The person in charge and the activities coordinator met regularly to review any issues raised at the residents' committee meetings. There was evidence of changes having been made as a result of these meetings. For example, there had been an issue about equipment in bedrooms, some residents were interested in a different selection of newspapers, a change to the level of physiotherapy provided was discussed at a recent meeting and a suggestion about a new choice of activities was also discussed. All these issues were recorded as being discussed with the person in charge and actioned accordingly. Feedback and suggestions were recorded with an action plan with timeframes. Some residents attended outside day services or were brought out by relatives or friends. A programme of varied internal activities was in place for residents. Information on the day's events and activities was prominently displayed in the centre. The inspector spoke to the activities coordinator who described how she delivered the programme which included both group and one to one activities. The inspector noted that there were a number of interesting arts and crafts at different stages of completion on display. Residents informed the inspector that they enjoyed music sessions and particularly outside musicians and would like to see more performances in the centre. The inspector passed on this request to the person in charge who agreed to review this provision. The inspector was told that residents' spiritual needs were met through regular prayers and Mass was celebrated by the local priest once a month in the centre. The inspector was informed that any other religious denominations were catered for as necessary. There was Closed Circuit Television (CCTV) cameras in place in a number of locations in the centre and there was a centre specific policy for their use. However, the inspector requested the provider representative to review all CCTV cameras in the centre to ensure that none potentially compromised the privacy and dignity of residents. For example, the inspector noted that there were CCTV cameras located in the lobby area near the main entrance to the centre, where some residents spent time sitting chatting or reading their newspapers during the day.

Judgment:
Substantially 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):

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

Findings:

Residents and relatives spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Overall, staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to residents. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs, as well as their likes and dislikes. An actual and planned roster was maintained in the centre. The inspector reviewed staff rosters which showed that the person in charge was on duty Monday to Friday and she was supported in her role by an ADON. Nurses were on duty day and night and the inspector observed practices and conducted interviews with a number of staff including the person in charge, ADON and staff from both day and night duty. Overall staff appeared to be supervised appropriate to their role and responsibilities. This was evidenced by speaking to person in charge, the ADON, a number of staff, the provider representative and a review of documentation including staff rosters, staff meetings, reporting arrangements and staff files. There was evidence that the person in charge monitored the care planning system to ensure that residents' support and care needs were met. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date health and social care needs. However, a number of day staff were observed leaving the morning handover meeting to answer call bells and therefore did not hear the full details during the handover meeting. This issue was addressed by the person in charge during the inspection and was identified and actioned under outcome 11 of this report.

Records viewed by the inspector confirmed that there was on-going staff training provided with numerous training dates scheduled for 2017. Staff told the inspector they were facilitated to undertake training by the person in charge. Mandatory training was on-going and staff had attended a variety of training courses and most staff had completed mandatory training in areas such as fire training. Mandatory training in manual handling and safeguarding was found to be up to date. Staff also attended training in areas such as the prevention of falls, infection control and medication management. However, as identified and actioned under outcome eight of this report one recently recruited staff had not attended fire safety training or participated in a fire

evacuation drill in the centre.

The inspector reviewed a sample of staff files which included most of the information required under Schedule 2 of the regulations. From the sample of staff files reviewed, a current vetting disclosure was in place for staff. The provider confirmed that all staff in the center had suitable Garda vetting in place. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector. However, as identified and actioned under outcome five of this report one action from the previous inspection in relation to requirements of staff records continued to be non-compliant as required under Schedule 2 of the regulations. One staff file did not have a record of the staff employment history and another staff file had only one reference instead of the minimum of two references as required by regulation.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Vincent Kearns
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:	15/11/2017
Date of response:	11/12/2017

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 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:

To ensure that the records set out in Schedules 2 are kept in a designated centre and are available for inspection by the Chief Inspector.

1. 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

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

the Chief Inspector.

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

The staff member that had documents missing has been given a definite timeline to have all documents returned or else be suspended from duties until such time. All other staff files have been audited. A new recruitment policy has been implemented whereby no staff member will begin duties until such documentation is in place.

Proposed Timescale: 31/12/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

To ensure that, where restraint is used in a designated center including environmental restraint, it is only used in accordance with national policy as published on the website of the Department of Health.

2. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

We have reviewed and changed our Restraint policy and procedure to include Environmental restraint and our continued efforts to reduce the incidence of using same. (Specific reference to door access)

Proposed Timescale: 08/12/2017

Theme:

Safe care and support

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

To take all reasonable measures to protect residents from abuse including financial abuse with the creation of an interest earning residents' account separate from the company's in order to be fully compliant with the Department of Social Protection guidelines for pension agents.

3. Action Required:

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

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

In the case of residents who either are unable or have no family or friend to handle their pension we have put in place the following controls. The pension will be electronically paid into Tipperary Healthcare main account. Each month the residents' contribution for fees will be deducted and the balance paid into a secure residents holding account each month that is referenced with the residents name on deposit.

Proposed Timescale: 30/11/2017

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:

To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre including the following:

- the unrestricted access to one of the sluice rooms had not been risk assessed
- the suitability of the closing/locking mechanism of the treatment room door required review as this door was found unsecured on two occasions during the inspection
- the storage of lighters in some residents bedrooms required a risk assessment
- the smoking risk assessment record required review to clearly demonstrate the rationale for the quantification of identified risks
- review the suitability of the two double doors into the main sitting/dining room to facilitate residents with a reduced mobility access this room
- two chairs in the nurses office and one chair in the main sitting room were damaged and potentially hazardous
- the storage of latex gloves and plastic aprons had not been risk assessed and were potentially hazardous to any resident with a cognitive impairment.

4. Action Required:

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

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

Fix a keypad Lock on sluice room 31/12/17

Fix the treatment room door lock 30/11/17

Risk assessment of lighters and removal where necessary 30/11/17

Smoking risk assessment review and checklist. 30/11/17

Install door hold open device to doors entering dayroom allowing ease of access.
31/12/17

Chairs in office and dayroom removed 30/11/17

Gloves had been risk assessed- review storage to either locked or covert storage
31/12/17

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

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 including the following identified issues:

- the top of the dryer in the laundry room contained an excessive amount of dust
- the sink in one of the sluice rooms was not adequately clean on both days of the inspection
- there were no rack available for the storage of urinals in one sluice room
- there was a crack in some tiles in a communal shower/toilet room which would potentially impede effective cleaning
- the cleaning practices as described to the inspector in relation to the changing of the mop heads were not keeping with best practices and prevention of cross contamination
- there was an uncovered waste bin in a communal shower/toilet room which may have been a hazard to residents with a cognitive impairment
- the extractor fan in the smokers room contained excessive dust
- there were two unclean hair brushes stored in a kidney dish on a laundry trolley in a bedroom corridor
- the fridge used to store residents' medications was not adequately clean and had visible stains on the door and bottom shelf of the fridge.

5. 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:

Immediate review of cleaning practices and staff training where required. 30/11/17

Purchase urinal rack 31/12/17

Fix tile crack 31/12/17

Removal of uncovered bin in sluice 30/11/17

Immediate notice to staff re hairbrushes and other personal items to be kept in residents lockers only – not on trolleys 30/11/17

Review of cleaning of medication fridge 30/11/17

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

To make adequate arrangements for detecting, containing and extinguishing fires including ensuring that the closing of all fire doors is unimpeded by any furniture or door wedges.

6. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

We have removed all door wedges from the building and reminded all staff that the use of same is prohibited

Proposed Timescale: 23/11/2017

Theme:

Safe care and support

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

To make adequate arrangements for reviewing fire precautions including personal emergency evacuation plans that may have required updating and to include details regarding the residents level of supervision when brought to a place of safety following evacuation.

7. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

We have developed a new PEEP chart in line with regulation which indicates details of supervision needed post evacuation and have included a quarterly review

Proposed Timescale: 28/11/2017

Theme:

Safe care and support

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

To ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

8. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case

of fire.

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

Review of induction process to ensure fire drill is carried out before employment commences.17/11/17

Continued efforts to ensure that all staff attend a fire training annually and a minimum of 2 fire drills each year. Fire drills are now being driven by the senior staff nurse on duty at more regular intervals.

Proposed Timescale: 17/11/2017

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:

To store all medicinal products dispensed or supplied to a resident securely at the center including medications requiring additional controls under the Misuse of Drugs Regulations.

9. 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:

Spoken to all Staff nurses regarding the importance of signing handover DDA check. We will continue to audit same to ensure compliance

Proposed Timescale: 17/11/2017

Theme:

Safe care and support

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

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 including the inclusion of an actual date of when a medication is prescribed for all medications to be administered to 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:

Continued review of medication charts to ensure that the Prescriber dates when medication is prescribed

Proposed Timescale: 20/11/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

To arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2) including ensuring that suitable arrangements for all staff to attend handover meetings without interruption.

11. 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:

Review of handover to allow same to be carried out without interruption while ensuring adequate staff remain on floor to monitor residents

Proposed Timescale: 15/11/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

To fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

12. Action Required:

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

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

Spoken to all staff during meetings to ensure prompt response to all complaints including improved reporting of same

Proposed Timescale: 20/11/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

To ensure that each resident may undertake personal activities in private including any areas in the centre with CCTV cameras are in place.

13. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

CCTV camera was disabled in front hall to protect residents privacy and dignity

Proposed Timescale: 24/11/2017