Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Woodlock Nursing Home
Centre ID:	0305
Centre address:	Portlaw Co Waterford
Telephone number:	051-378216
Email address:	woodlock@mastergroup.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Tim Kelleher
Person in charge:	Eimear Fitzgerald
Date of inspection:	24 August 2011
Time inspection took place:	**Start:** 15:00hrs **Completion:** 20:00hrs
Lead inspector:	Noelene Dowling
Support inspector:	Catherine O'Keeffe
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☒ Information received in relation to a complaint or concern ☐ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

This centre closed on 12 December 2011 at 15:00hrs following cancellation of the centre's registration by order of the District Court.

Woodlock Nursing Home provides residential accommodation to 30 older persons and two persons under the age of 65, on a long-term basis. The premises were originally managed as a nursing home by a congregation of religious sisters. Five members of the religious order live in separate accommodation within the premises and share the entrance to the nursing home.

The building is a large two-storey, over-basement premises. There is a large entrance hallway, and the chapel, parlour, and administration office are located off this hallway. Steps lead to double doors, which give access to a large internal lobby, off which the male five-bedded ward is located. Residents in this ward share one bathroom which has been renovated to include an assisted shower, toilet, and wash-hand basin and there is a separate toilet available. The dining room, day room and kitchenette (which is used for serving meals), are also located on this floor. Two public toilets and a staff shower are situated on this floor, along with access to the religious community accommodation and administration office.

There are sixteen single bedrooms on the first floor, with one female five-bedded ward. Residents on this floor share two bathrooms, one with shower, wash-hand basin and toilet and one with a bath, toilet and wash-hand basin. One single bedroom has an adjoining en suite with shower, toilet and wash-hand basin. There are two additional toilets on this floor. The sluice room and staff toilets are also located on this floor. A large stairway and circular surrounding balcony create a mezzanine floor space which includes one single bedroom a lift and office for the person in charge. The basement contains the main kitchen, boiler room, laundry and various other unused rooms.

The centre is located in its own grounds, with a long driveway and ample car parking spaces. The gardens contain a large lily pond to the rear and various unused outhouses. The drive and surrounds are used as a walking area for local people.

Location

The centre is located in the village of Porlaw Co Waterford.

Date centre was first established:	March 2007
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	7

Dependency level of current residents	Max	High	Medium	Low
Number of residents	5	5	8	5

Management structure

Tim Kelleher is the registered provider on behalf of Woodlock Nursing home Ltd. Eimear Fitzgerald is the Person in Charge. The care assistants and nursing staff report to the Person in Charge. The catering, household and maintenance staff report to the Administrator who reports to the Person in Charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	2	5	2	1	0	0

Background

This was the tenth inspection of this centre, undertaken by the Health Information and Quality Authority. Previous inspections were carried out on 18 May 2010, 23 August 2010 and 19 October 2010 respectively and 26 January 2011. A triggered inspection was undertaken on 17 November 2010 in response to a notification that the heating system had been out of order since 14 November 2010. Two monitoring visits were undertaken on 20 April 2011 and 17 May 2011 respectively. Follow-up inspections were undertaken on 30 May 2011, and 20 July 2011.

The monitoring visit of 17 May 2011 resulted in an immediate action plan being sent to the provider with regard to medication management. A further immediate action plan was issued to the provider following the inspection of 30 May 2011 which required the provider to install an adequate and safe call-bell system and repair or replace the dishwasher. Further inspection was undertaken on 20 July 2011 which incorporated actions required from all previous reports. The provider was issued with an action plan following this.

Findings of all previous inspections demonstrated that the provider had made insufficient progress in implementing the required changes outlined in previous inspection reports and many of the agreed timeframes had elapsed with the significant issues remaining unresolved.

This inspection was undertaken to monitor resident's health and wellbeing, and in response to information received by the Authority in relation to delays in relatives being able to access the premises and residents finances. This inspection focused on healthcare, health and safety, access by visitors or relatives to the centre and management of resident's finances.

Summary of findings from this inspection

Inspectors found that arrangements had been made which will ensure that relatives can gain access to the premises in a timely manner without undue restriction on visits.

While medication management and storage was in line with regulations and guidelines unacceptable delays were still occurring in prescribed medications being available to residents.

The findings also demonstrate that there was significant improvement necessary in the clinical care of residents and assessment of their overall needs and condition. The inspection identified an immediate need for review of residents' pressure sore areas and training for staff in the identification, management, prevention and documentation of such conditions .The findings also demonstrate a requirement for staff training in the use of recognised assessment and monitoring tools relevant to the resident population.

Health and safety concerns and risk management strategies were again identified in relation to adequate infection control and risk to residents from the first floor external balcony and adequate knowledge by staff of fire procedures. Details of residents' finances available in the centre were minimal but did demonstrate the need for improvement in recording and accounting systems.

The Action Plan at the end of this report documents the actions the provider is required to make. Four of these actions require an immediate response from the provider.

Issues covered on inspection

Healthcare of residents:

The four care plans examined by inspectors showed evidence of regular and timely general practitioner (GP) review of residents and referral to allied health services. Residents were seen to have physiotherapy support regularly, and access to other clinical specialists. Inspectors reviewed the storage and identification of controlled drugs and found that practices were in line with guidelines and all such drugs were accurately labelled for the individual resident. However, inspectors again found that a resident prescribed a medication by the GP did not receive this medication until 16:00hrs the following day.

Inspectors found that there were significant improvements needed in the assessment, monitoring and implementation of interventions outlined as necessary for residents. This was primarily related to the two specific issues, monitoring of dietary and fluid intake and wound or pressure area care.

The dietician who had commenced work with residents in June 2011 was in the process of reviewing the residents for nutrition and weight management. Inspectors saw details of revised dietary plans in residents' records. Staff had commenced reviewing the Malnutrition Universal Assessment Tool (MUST) for residents. One such assessment examined demonstrated that the tool was not accurately used; the assessments were contradictory to the information gleaned from the resident's weight and dietary intake. The person in charge agreed with this finding.

The dietician records seen for one resident indicated that the resident was to be weighed weekly to adequately monitor weight loss, while a revised diet was implemented. However, the resident's weight record indicated that the resident was weighed monthly, despite the resident's name on a white board at the nursing station advising weekly weights. Staff were found to be utilising two separate dietary and fluid intake monitoring systems and inspectors found that these were not consistent. Fluid intake for residents was not accumulated to ensure it was sufficient and the intake following 20:00hrs was not recorded in some instances. The dietary tool utilised in the dining room was found to contain conflicting entries, which did not give an accurate finding. The person in charge agreed that the dietary changes, implementation of the monitoring tools and interventions based on the cumulative data collected in the monitoring tools would require additional training for staff.

Three of the care plans examined identified significant pressure areas and wounds. One resident was identified as having five separate wounds, and two others with three separate pressure areas. Two of these were identified in records as being grade two, with a further grade three pressure area also identified. On examination of the pressure area care and wound care plans inspectors found them found them to be inconstant, with the frequency of treatment outlined not followed. For example, one resident's treatment plan outlined treatment every five days, but no treatment was recorded for 13 days, and another, which was identified for treatment daily and

as required a seven day gap was evident in the records. There was no evidence of how the assessment and grading or interventions for these pressure areas was decided upon and the documentation was inconsistent and unclear.

The person in charge informed inspectors that she was not aware of the presence of pressure areas of this seriousness. On examination of the records with inspectors, she indicated that the documentation was inaccurate, and misleading. A nurse undertook to re-evaluate the condition of one resident and found that that the details in the records were inaccurate. They did not reflect the residents wound status accurately and in fact indicated that the residents' condition was of a more serious status than was in fact the case. However, the re-examination also identified that the treatment plan outlined was not being followed for the pressure areas which did exist. For example, the GP had recommended that a specific dressing be applied. However, this had not been implemented.

This finding raised serious concerns for the inspectors in terms of clinical experience and skill in skin care and pressure area management, prevention and assessment. It also indicated that clinical governance and overview of staff practices was not robust.

Health and safety of residents, staff and visitors:

Inspectors again found a number of concerns in relation to the health and safety of residents and staff aside from those identified in previous reports, which the provider has not resolved. The sluice facility was found to be crowded with residents' laundry, which posed a risk of cross infection. Inspectors observed an obviously unclean scissors in the container utilised for wound dressing.

Inspectors observed that the door leading to the balcony on the first floor from the female five-bedded ward was open in the late evening. There were no staff present. This action poses a direct and serious risk to residents should they wander or walk on to the balcony and subsequently fall to the concrete below. Staff informed inspectors that should any resident who can mobilise independently be on the first floor this door would not be open.

Inspectors appreciate the benefit to the residents in this shared ward of having the door open, accessing fresh air and the balcony. However, no health and safety or risk assessment had been undertaken to manage the risk associated with this while also ensuring that residents and staff had access to fresh air. Dependency on staff supervision in such circumstances was not an adequate safety measure; staff may be needed elsewhere or momentarily distracted. For example, the provider has consistently failed to put an adequate call-bell system in place; it is staff from the first floor who respond to the call-bell for the male ward on the ground floor, thereby removing them from the top floor.

Inspectors interviewed a staff member in relation to the procedure for the evacuation of residents in the event of fire on the first floor. The staff member was unsure as to how to unlock the fire ext doors on the first floor. The nurse on duty during the day carried the key to the exit doors for this floor and staff have to locate the nurse in order to exit the premises in the event of a fire. Staff also provided incorrect details as to how one identified resident, who requires a specific evacuation route would be

evacuated in the event of a fire. The person in charge informed inspectors that fire drills had been held recently but could not access the record of this.

Residents' finances:

Inspectors asked to view details of the residents' finances, charges to residents for expenses incurred outside of fees, and the financial records of one identified resident who the provider acts as agent for. Inspectors found poor recording and management systems in place. Collection of the resident's pension was logged in petty cash by the provider. Some of this money was to be utilised toward payment of the centre fees.

There was no record of the resident or relative on his behalf, signing that this money was to be managed in this way, or that any percentage of this money was held on behalf of this resident for his personal use, There were no receipts to indicate if any had been spent on such items and if the resident or relative was informed of this. No account details were held in the centre and the person in charge stated that she did not have access to them.

The provider was requested to forward full details of all accounts, including, charges to residents, charges for additional services and receipts, and statements provided to relatives for such services to the Authority.

Staffing:

Inspectors observed that there was a suitable skill-mix and adequate number of staff on duty to meet the needs of residents. Inspectors examined the duty rosters and were satisfied with the number of staff employed and scheduled to work both day and night.

In response to a complaint and following information received by the Authority the person in charge informed inspectors that she had put an additional care assistant on duty from 12:00hrs until 20:00hrs, to facilitate relatives and visitors access to the premises. Examination of the roster verified this action. Two relatives informed inspectors that they did not experience long waits to gain access to the centre.

The person in charge informed inspectors that they had identified a current staff member to act as key senior manager in the absence of the person in charge but this had not yet been implemented.

Inspectors examined a personnel file for a long serving staff member and found that Garda Siochana vetting had not been applied for, only one reference was available and no evidence of medical and physical fitness was provided.

Training:

Inspectors examined records of core training provided for staff. These records indicated that manual handling training including mechanical lifting of residents had taken place on May and April 2011 for a total of 18 care assistant staff and one member of nursing staff.

The person in charge informed inspectors that further training in manual handling was to be scheduled in 2011 and all staff would at that point be trained or have had their training updated. Records indicated that additional training for staff in elder abuse had taken place on 10 August 2011 facilitated by an accredited trainer, for 22 care assistants and all nursing staff.

Report compiled by:

Noelene Dowling
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

25 August 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
18 May 2010 and 19 May 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
23 August 2010	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
19 October 2010	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
17 November 2010	☐ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Triggered inspection ☐ Announced ☒ Unannounced
26 January 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced

20 April 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
17 May 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
30 May 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
20 July 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report [*]

Centre:	Woodlock Nursing Home
Centre ID:	0305
Date of inspection:	24 August 2011
Date of response:	31 August 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The person in charge has failed to comply with a regulatory requirement in the following respect: Residents identified with pressure sore areas did not have access to adequate clinical or specialist assessment and treatment.
Action required: Provide the identified residents with access to specialist assessment and support in relation to wound assessment, management and treatment.

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

Reference:

Health Act 2007
Regulation 25: Medical Records
Regulation 8: Assessment and Care Plan
Regulation 6: General Welfare and Protection
Standard 11: The Resident's Care Plan
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Authority's Timescale:**
Provider's response: The person in charge has contacted the tissue viability nurse and spoken to her regarding specific guidelines on the specific wounds we currently have. The general practitioner will review wounds on his rounds and if a change in treatment is indicated he will order same. All staff have currently read the wound care guidelines (national document) and a centre-specific policy on prevention and management is in progress. The person in charge has asked the tissue viability nurse to come and give a presentation to the nursing staff on wound care and revert with a date for same in the next week. Current wound charts will be updated and implemented within the next week. The tissue viability nurse will also forward to us this week a poster for nursing staff to refer to. The nutrition and fluid intake of all residents is currently being monitored and Waterlow scores are being done on all residents. One of our present wounds is a venous leg ulcer treated with antibiotics and this resident has been referred to a vascular surgeon. As we had two new staff nurses and one nurse returning from maternity leave together with a recently appointed person in charge, it is prudent that we are allowed sufficient time to ensure consistency of practice together with clear guidelines for the prevention and management of pressure areas should pressure wounds occur. Clear guidelines are being developed in line with the national wound care guidelines 2009.	 Immediate

2. The person in charge has failed to comply with a regulatory requirement in the following respect:

Wound prevention and management was not guided in practice by evidence-based nursing care.

Action required:

The person in charge will implement a wound prevention and management policy that is evidence-based and adheres to best practice guidelines.

Action required:

The person in charge will ensure that all staff receive training in, are familiar with, and implement this policy and procedure so that a high standard of evidence based nursing practice is delivered to the resident.

Reference:

Health Act 2007
Regulation 25: Medical Records
Regulation 8: Assessment and Care Plan
Regulation 6: General Welfare and Protection
Standard 11: The Resident's Care Plan
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Authority's Timescale:
Provider's response: Our wound management policy is being developed in line with national guidelines. Appropriate training is to be provided to staff.	Immediate

3. The provider has failed to comply with a regulatory requirement in the following respect:

There was a consistent failure to implement adequate risk management and health and safety procedures through out the centre thereby risking accident or injury to residents and or staff.

Action required:

Implement safety measures which ensure that residents on the first floor have access to external air, and grounds in safety.

Action required:

Ensure that staff take proper precautions against the risk of infection by adequately cleaning and storing equipment used for residents such as scissors.

Reference:

Health Act 2007
Regulation 19: Premises
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Authority's Timescale:**
Provider's response: As mentioned in the completed action plan submitted on 29 August 2011, our risk management policy is being reviewed and procedures continue to be refined and made more centre-specific as required. Work on this is ongoing.	 Immediate

4. The provider/person in charge has failed to comply with a regulatory requirement in the following respect:

Examination of residents' records demonstrated that staff did not comply with interventions directed by clinicians or adequately and consistently monitor and support residents' health and wellbeing.

Action required:

Ensure that staff consistently implement interventions directed by clinicians to include residents' dietary needs, fluid intake and weight monitoring.

Action required:

Provide training for staff in the use of, and implementation of recognised assessment and monitoring tools.

Reference:

Health Act 2007
Regulation 9: Healthcare
Regulation 8: Assessment and Care Plan
Standard 13: Healthcare
Standard 11: The Resident Care Plan

Please state the actions you have taken or are planning to take with timescales:	Authority's Timescale:
Provider's response: Staff monitoring and adherence to directions by clinicians to include resident's dietary needs, fluid intake, and weight monitoring is being undertaken by the person in charge. This is being augmented by further training in assessment tools as required.	Immediate

5. The provider has failed to comply with a regulatory requirement in the following respect:

Residents did not have access to prescribed medications in timely manner.

Action required:

Ensure that residents receive their prescribed medications in a timely manner

Reference:

Health Act 2007
Regulation 9: Health Care
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Prescriptions issued by the residents' general practitioner are sent directly by him to the pharmacy and delivered to the home by the pharmacist. A meeting has taken place between the person in charge and the general practitioner to ensure prescribed medications are received in a timely manner. All emergency medications are available within an immediate timeframe and changes to prescriptions and start times is being reviewed by the general practitioner and the acting key senior manager. This will be monitored by the person in charge.	Ongoing

6. The provider has failed to comply with a regulatory requirement in the following respect:

Failing to maintain adequate signed records and receipts of resident's finances for on identified resident.

Action required: Provide residents with accurate, up-to-date records of their monies held or utilised to pay fees and ensure that residents have documented access to a percentage of these monies, for their personal use and that this is receipted.	
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Regulation 7: Residents' Personal Property and Possessions Standard 9: The Resident's Finances	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An up-to-date record of monies held or utilised to pay fees has always been held by the provider and is maintained and updated on a regular basis by the provider. A copy of this record was forwarded on request to the Authority on 5 August 2011. This is maintained directly by the provider and kept at the office in Killarney where all invoicing, statements and accounts are kept and maintained. A monthly invoice is sent to all relatives/residents. This monthly invoice shows the balance forward from the previous month, any payments received from the resident or relative since the previous invoice, the monthly gross fees, any subvention or fair deal deducted plus any additional charges incurred by the resident from time to time. The only additional charges have been for chiropody and hairdressing. The provider only acts as agent for one resident and has done so only since July 2011. Prior to this date, the support staff supervisor employed by the company acted as agent in her personal capacity as she knew the resident and had been requested to do so by the next of kin. From July 2011, this was taken over by the provider and procedures/records are being revised to record separately a percentage of this pension collected for his personal use. The information requested by the lead inspector will be forwarded under separate cover. All other residents' finances are maintained by their next of kin or other relative.	 15 September 2011

7. The provider has failed to comply with a regulatory requirement in the following respect: Staff files did not all contain the matters set out in Schedule 2.	
Action required: Put in place recruitment procedures to ensure no person is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each such person.	
Reference: Health Act 2007 Regulation 18: Recruitment Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As mentioned in the completed action plan submitted on 29 August 2011, our recruitment procedures are in place and are being updated where and when necessary to provide a more robust system and most recently to include centre-specific reference request forms and medical declarations. Staff files are continuously being examined and updated for the requirements of Schedule 2.	30 October 2011

8. The provider has failed to comply with a regulatory requirement in the following respect: Not ensuring that staff can easily exit fire exit doors and are familiar with the procedure for evacuation of residents who require specific support.
Action required: Put in place an adequate system for opening the fire exit doors, which staff are familiar with.
Action required: Ensure by means of fire drill or training that staff are familiar with the procedure for the evacuation of residents, especially those residents who require a specific evacuation route.

Action required: Maintain in a safe and accessible place in the centre, a record of all fire practices which take place.	
Reference: Health Act 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The keys to the first floor fire exit doors, which are held by the care assistants on night duty, are being distributed to care assistants on day duty (two care assistants upstairs and one care assistant downstairs). The nurse on duty carries a set at all times. This means that are four sets of keys available to staff for the fire exits from the building. In the event of emergency, all exit doors on the ground floor and basement have an emergency release panel, which can be manually released in the event of a power failure or emergency. The person in charge was unable to locate record of fire drills carried out, which was requested by Ms Dowling, lead inspector during the inspection visit, but it was subsequently located as it had been temporarily out of place. Further fire drills are to be carried out to ensure that staff are adequately trained in the fire exits and the evacuation routes for each resident. The details of the fire drills held and the number of staff who attended them are as follows; ▪ 16 March 2011 – eight staff ▪ 13 May 2011 – 11 staff ▪ 16 June 2011 – seven staff ▪ 13 July 2011 – eight staff ▪ 31 August 2011 – eight staff. A record is kept in the fire register held at reception. A record of the fire practices (incl. fire register) is kept at reception.	 15 September 2011

Any comments the provider may wish to make:

Provider's response:

The provider is committed to implementing the necessary requirements and to comply with the regulations but has been frustrated by difficulties in recruitment and finance due to the difficult economic climate and most recently by the issuing of the Notices to the provider. For the record, the provider has, to date, incurred almost €200,000 on equipment and capital improvement works in Woodlock and is anxious to proceed with all necessary works outstanding. Since the receipt of the Notices, the provider has at all times attempted to engage constructively with the Authority and has made a number of requests for a meeting with the Chief Inspector and/or the Regional Operations Manager to clarify the registration issue and agree matters.

There are no outstanding matters that are not achievable, but without clear prior agreement of the specific parameters with the Chief Inspector, the provider is unable to satisfy the conditions for the drawdown of the necessary finance.

It is both frustrating and disheartening to learn of public nursing homes that are being registered by the Chief Inspector where the regulations are being waived, despite the Authority saying they do not have a suitable physical environment under the new regulations, no plan to carry out improvements and no letter from a fire consultant that all requirements of the statutory fire authority have been met.

Provider's name: Timothy Kelliher, Woodlock Residential Care Limited

Date: 31 August 2011