Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Woodlock Nursing Home
Centre ID:	0305
Centre address:	Portlaw
	Co Waterford
Telephone number:	051-378216
Fax number:	051-387625
Email address:	woodlock@mastergroup.ie
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered provider:	Tim Kelliher
Person in charge:	Eimear Fitzgerald
Date of inspection:	20 July 2011
Time inspection took place:	**Start:** 11:00hrs **Completion:** 15:30hrs
Lead inspector:	Noelene Dowling
Support inspector(s):	Catherine O'Keeffe
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 met 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 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 six-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 Portlaw, 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. 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. There is no appointed key senior manager to deputise in the absence of 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	3	1	2	0

Background

This was the ninth inspection 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 and a follow-up inspection was undertaken on 30 May 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.

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 report incorporates the findings and progress of the monitoring inspections undertaken on 20 April 2011 and 17 May 2011 and the immediate action plan issued following inspection on 30 May 2011. It also incorporates some of the actions outlined by the provider for completion or to commence in his response to the Notice of Proposal to Refuse Registration.

Summary of findings from this inspection

This inspection found improvements in residents' medical care and review by the general practitioner (GP) and referral to allied health services. Small changes to residents' routines were also identified. Improvements were still required in the monitoring of residents health, use of recognised assessment tools, medication management, complaint management, and end-of-life care.

No improvements were found in relation to:

- fire safety
- risk management
- the experience and therefore suitability of the person in charge
- availability of a key senior manager
- adequacy of the number of nursing staff
- maintenance and upkeep of the premises and grounds
- recruitment practices
- supervision of staff
- access to the premises
- emergency planning
- systems to review the quality and safety of care
- policy development and implementation including policy on the prevention, detection and reporting of abuse.

Concerns remain in relation to the providers actions when issues which constitute potential harm to residents emerge in view of the lack of action taken when such an incident occurred in February 2011.

Actions reviewed on inspection:

1. Action required from previous inspection:

Provide written details outlining the specific arrangements for periods when the person in charge is absent from the centre.

The provider has not appointed a key senior manager to cover in the absence of the person in charge.

2. Action required from previous inspection:

Employ a suitably qualified and experienced person in charge.

No action had been taken on this. The provider had recruited a qualified nurse on 21 February 2011 to replace the previous person in charge. However, the person appointed does not have the required minimum of three years experience in geriatric nursing and is therefore not eligible to hold the post of person in charge. The provider was clear of this requirement by the inspector prior to recruiting this person. The provider has been unable to source the required last employer reference for the person in charge and the Authority had not received the required self-declaration signed by a solicitor.

3. Action required from previous inspection:

(a) Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

(b) Adequately assess the risk to residents of the use of any methods of restraint and ensure that such use is regularly reviewed.

(c) Put measures in place to prevent injury to residents from the internal balcony.

(d) Put an emergency plan in place.

No adequate actions have been taken on this. Inspectors reviewed the risk management policy and found that it was not centre-specific, and appeared to have been imported from another service and not amended to be specific to this centre. It made references to a number of processes, which are not specific to the centre, such as, data collection and analysis, systems analysis of clinical incidents, twice yearly meetings of the fire safety committee and the Hazard Analysis Critical Control Point (HACCP) committee which are not implemented. No audits of incidents or accidents have been undertaken.

The health and safety audit undertaken has not been amended to adequately identify, asses and control risks identified in the premises, such as; the risk of the

inadequate call-bells and lights not working or the inadequacy of the sluice room or the lack of a dishwasher.

The height of the internal balcony identified in all previous reports had been raised to prevent a risk to residents of falling over the balcony onto the tiled floor below however, this is not effective and no further actions have been taken by the provider to address this.

The emergency plan remains inadequate and no adequate arrangements have been taken in the event of loss of power. The person in charge has commenced making tentative arrangements with the Health Service Executive (HSE) in the event that residents have to be evacuated. However, staff were not aware of this plan and there was no clear guidelines for contacting local emergency service personnel. This plan has not been completed and implemented.

4. Action required from previous inspection:

Put in place a policy and procedure for the prevention, detection and response to incidents of abuse of residents.

Ensure that staff receive appropriate training in the prevention, detection and reporting of suspicions of abuse.

No action had been taken. Policy had not been amended to adequately reflect the centre management profile and the reporting systems in the event of an allegation or abuse occurring. This is especially unacceptable in view of the fact that the provider had failed to act in an appropriate manner to protect residents, seek appropriate medical care, and report to resident's next of kin or the relevant authorities when an incident of abuse was reported to him on 13 February 2011. This resulted in a considerable and unacceptable delay in the safeguarding process being put in place.

This was subsequently reported by the person in charge and the elder abuse officer for the Health Service Executive was involved. The resident was assessed by the GP. The correspondence viewed by inspectors on 17 May 2011 and 30 May 2011 indicated that the elder abuse liaison officer was awaiting contact from Gardai Síochána in relation to their view or intended actions on this matter.

The person in charge was requested to revert to the Authority following the return of the social worker to ascertain if the assessment undertaken was satisfactory or if further assessment was necessary in order to ascertain if there is further risk of such an incident occurring or if additional clinical care is required. This has not occurred.

Training for staff in the prevention, detection and reporting of abuse has been agreed for 3 August 2011. This training while valuable will not be effective without adequate policy implementation and the commitment of the provider to act according to best practice and regulation when incidents occur.

5. Action required from previous inspection:

a) Provide sufficient numbers of toilets, and wash-hand basins, baths and showers at appropriate places in the premises.

(b) Provide a sufficient number of toilets which are designed to provide access for residents in wheelchairs, having regard to the number of residents using wheelchairs in the designated centre.

(c) Provide adequate sluice facilities.

(d) Make the driveway safe and suitable for use by residents and relatives.

(e) Review the usage of the shared wards to ensure that they numbers do not exceed the standard of no more than two residents per room except in a high dependency room within the required timeframe.

(f) Put in place a system to ensure that relatives and visitors can access the premises after office hours.

(g) Put in place an adequate program of routine and suitable maintenance of the building and a plan for renewal of fabric, decoration, furnishings and facilities for resident use.

No actions have been taken on this. Furnishings and fittings remain in poor condition, with lockers with no doors in place or with no handles on the doors. The provider had stated that he would commence a full refurbishment schedule of the premises and fittings between May and September 2010. No works have commenced. Inspectors observed that the walls in the day room, which had been damaged following a leak in November 2011 was still not repaired and was unpainted.

Inspectors again found that routine maintenance tasks were not been carried out. The sink in the female bedroom, which inspectors were informed was fixed following the inspection in January 2011 was found not to have been attended to and staff could not use it. No works have been undertaken in the sluice room or equipment provided to make it fit for purpose. This remains a significant risk in the containment and control of infection.

One bathroom upstairs had been renovated and contained a walk in shower. This was completed in March 2011. The remaining bathroom upstairs is not equipped for use by residents and the overhead shower does not work. Records however, indicated that resident showers take place weekly at timeframes which take residents choice into account. The two single toilets on the first floor still require renovation in order to make them suitable for residents who require support.

Three of the residents' were known to have an infection which would present a risk of cross infection. The policy on infection control was still found to contain no centre-specific instructions for staff to follow.

Access to the external grounds remains problematic with paving and ramps uneven and no adequate or appropriate garden space available to residents. The doors leading from the day room to the garden remain locked and only the nurse on duty carries a key.

The person in charge had made out a list of equipment requirements including new and more appropriate beds and rails which she informed inspectors she had informed the provider was vital. These have not been provided.

Adequate action has not been taken in relation to ease of access to the premises. The person recruited by the provider to undertake administration tasks and answer the door works 40 hours per week, and finishes duty at 20:00hrs. This timeframe is limited and the provider informed the Authority in his representation that this would be rectified by the provision of an additional person to answer the doors outside of these hours or an alternative means of entry.

Inspectors reviewed a complaint where a relative could not access the building on one Sunday morning recently. As an interim measure the person in charge has allocated a care assistant staff to work form 12:00hrs until 20:00hrs on Sundays and be available to answer the door. However, this does not adequately allow access form 20:00hrs or on the remaining day when the administration staff is not available. This is effectively a restriction of visiting times.

6. Action required from previous inspection:

(a) Put in place adequate policies in regard to the safe administration of medication in line with An Bord Altranais guidelines 2007.

(b) Ensure that each resident's medication is regularly reviewed as required and at not less than three-monthly intervals.

(c) Routinely monitor the use of and reactions to medication.

(d) Accurately document all medications prescribed and discontinued.

Some improvements were found but significant concerns still remain. Policy on medication management was found to contain all of the details required by the regulation and guidelines. There was evidence that reviews of medication and their usage was continuing with regular consultation with the GP.

The process of monitoring the use pf psychotropic medication was found to be continuing. This was accompanied by a detailed individual synopsis of the reason why such medication would be administered, the possible side effects and any contraindications.

However, inspectors noted unacceptable delays still occurred in resident's receiving their prescriptions. Inspectors found that one resident had been prescribed medication the previous day but had not received it by 15:00hrs on the day of inspection.

Inspectors also found that a resident prescribed one dosage of medication was in fact given a lesser dose as the prescribed dosage had run out. Inspectors noted that an MDA scheduled drug prescribed for one resident did not have the resident's name and detail on the medication container which could pose a risk to resident's safety.

7. Action required from previous inspection:

(a) Facilitate each resident's access to physiotherapy, chiropody, occupational therapy, speech and language therapy or any other services as required by each resident seating 19 November 2010.

(b) Maintain records of all healthcare referrals and follow-up appointments.

This action had been implemented. There was evidence of referral for two residents to psychiatric services and one had been re-evaluated with a full report available. Physiotherapy is also available. The provider had contracted a dietician who commenced in June 2011 who will be available on day per month and has agreed to undertake one days training for staff in the support of residents nutritional needs. This practitioner was in the process of assessing each resident and making recommendations, and had already recommended an increase in resident's access to fruit in their diets. Progress will require monitoring.

8. Action required from previous inspection:

Continue the process of setting out each resident's needs in an individual care plan developed and agreed with the resident.

Inspectors examined four residents care plans and found that while progress was being made much work is still required in the consistent implementation and management of residents' clinical care and assessment of need.

Inspectors found that staff were not utilising a recognised tool for assessing residents dependency levels and subsequently implementing appropriate support systems. Dependency was been assessed only on the number of staff needed to support residents with mobility and transferring. This is not an effective, comprehensive or evidenced-based model for assessing resident's dependency.

Improvements were also found necessary in practices in relation to end-of-life care for residents. A resident had made an informed decision to decline further medical treatment. The inspectors reviewed the written documentation and agreement for this action on the residents file and the resident's wishes were respected.

Staff nurses informed inspectors that the hospice care team had reviewed the resident and advised on appropriate nursing care following this decision to cease treatments. This was not recorded on the resident records. The residents care plan was not amended for the intervening period, when it was known that the residents death was imminent, to demonstrate appropriate medical and symptomatic care of the resident.

Inspectors found that the nursing records demonstrated a significant and unacceptable lapse between the last review of the resident by nursing staff and the residents passing away. Records demonstrated that the resident was last reviewed and attended to at 02:00hrs by nursing staff. The next entry in the records was at 10:00hrs to confirm that the resident had passed away. Although staff informed inspectors that this was not an accurate reflection of the care provided there is no evidence that end-of-life care for this resident was managed in a careful, sympathetic and clinically appropriate manner.

No changes have been made to the system for assessing the need for bedrails usage or the risks identified for their usage. The assessment tools are not been adequately utilised and inspectors again found that the nursing staff were completing these documents without consultation or consent from the resident or relatives.

9. Action required from previous inspection:

All assessments/ monitoring tools including weight and fluid intake necessary must be consistently applied and adequately reviewed.

Progress has not been sufficient or effective. Fluid and weight monitoring tools are been utilised but not sufficiently and effectively. Inspectors noted that one resident who requires full assistance with fluid intake did not have his fluid intake charted on two occasions after 18:00hrs and 20:00hrs. The intake was not accumulated and the intake assessed for sufficiency. Another resident who is also fully dependant did not have his intake monitored on one occasion after 13:00hrs.

10. Action required from previous inspection:

Provide each resident with a safe supply of fresh drinking water at all times.

Inspectors observed that staff was supporting residents with access to fluids in the day rooms. However, the findings noted above in relation to residents whose fluid intake requires monitoring demonstrates that this had not been adequately addressed.

11. Action required from previous inspection:

Increase the numbers of nursing staff employed.

The provider now has a total of six nursing staff which is an increase of one and on occasion a second nurse is rostered during the day to support residents. However, the findings of this follow up in relation to health care and assessment of residents does not demonstrate that this is effective. In addition, the person in charge reported that she has to undertake regular shifts as nurse on duty as a result of staff shortages and illness. The findings of this follow-up inspection demonstrate that this has impacted on her ability to adequately undertake management duties, supervise staff and develop and implement adequate centre-specific policies.

12. Action required from previous inspection:

Put in place recruitment procedures to ensure no staff member 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 person.

Recruitment procedures remain inadequate and unsafe. References sourced provide no confirmation of length of employment or dates of employment and curriculum vitae was not used to identify the most appropriate or recent employer, and in one case all three references came for the same employer. In one file examined the most recent employer was not contacted. There was no evidence of verification of references provided by staff .The person in charge informed inspectors that the application for Garda Síochána vetting was been processed but, did not have evidence of this.

No formal appraisal or supervision system has been implemented. At the previous inspection on the 30 May 2011 the person in charge stated that she had commenced a system of staff rotation in response to a number of incidents regarding medication management. Two staff who normally works nights rotated to days so that they can work under the direct supervision of another nurse or the person in charge. However, examination of the roster demonstrated that this had only occurred for one staff for a period of two weeks which did not adequately address the need for monitoring and supervision of clinical practice.

13. Action required from previous inspection:

(a) Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.

(b) Review the competency and skill of long standing care staff to determine their need for further training and make suitable arrangements to meet their identified training needs.

(c) Implement a staff training programme that ensures staff meet the changing needs of residents and understand and adhere to the policies and procedures of the resident care setting.

No actions have been taken on this. A systematic review to include long serving staff has not as yet been undertaken. No dates were available for Sonas training as previously agreed and the internal training in responding to challenging behaviours which inspectors were informed was planned for 30 May 2011 had not taken place.

14. Action required from previous inspection:

(a) Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

(b) Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.

Inspectors observed some changes to residents' routines and variety of activities with activities including a suitable DVD, flower arranging, fit-for-life and bingo, taking place for those who can participate.

The presence of a care assistant in the day room, which was a strategy implemented in March 2011 as a result of the incident of abuse which had occurred in February 2011 is having a positive impact and could be seen to have resulted in more interaction with residents. Inspectors observed that there were flower pots placed outside the day room within resident's view which enhanced the environment. Staff informed inspectors that they are trying to ensure that residents get out in the fresh air regularly.

The grounds outside the resident's day room remain uneven and not conducive to residents utilising it. The seating available outside consists of two wooden benches which are not suitable seating for the resident profile. Improvements are still required in this action.

16. Action required from previous inspection:

Put in place all operational policies and procedures required by the regulations.

Policy development has not been completed. The last inspection which took place on 30 May 2011 found that the policy on restraint, and the prevention, detection and reporting of abuse was not centre-specific. This has not been remedied and further policies including risk management and emergency planning are not adequate or specific to the centre.

17. Action required:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of:

any allegation of misconduct by any person who works at the centre
any serious injury to a resident.

Examination of the accidents and incident logs demonstrated that the provider has still not complied wit the requirement to notify the office of the Chief Inspector of any accidents or incidents occurring in the centre. Specifically of the occurrence of grade two pressure wounds.

18. Action required from previous inspection:

Ensure that equipment provided for use by residents specifically the call-bells system are suitable for purpose and maintained in good working order.

Ensure that essential items such as dishwashers are replaced in a timely and efficient.

No actions had been taken on this. The call-bell system was again found to be unsafe. The control board for the call-bell system is located on the first floor and a conduit system is used to connect the ground floor. When a resident in the male ward downstairs rings the call-bell it is dependant on a staff in the upstairs area to hear it and identify the location and as observed by inspectors call down the stairs for a staff downstairs to respond. This is particularly unsafe when the layout of these premises is taken into account.

A highly dependant resident was again found in bed without access to the call-bell.

Inspectors found that the dishwashers, which were out of order on the inspection of 17 May 2011, had not been repaired or replaced. Documents demonstrated that these were in fact out of order since 10 May 2011.The person in charge stated that a new dishwasher had been ordered on 30 May 2011 but would take a week to arrive.

In his response to the action plan the provider stated that a replacement would be available by 30 June 2011 and this had not occurred. Dishwashing continued to be undertaken by hand which was unacceptable and a risk to the health of the residents.

19. Action required from previous inspection:

Make adequate arrangements for containing and extinguishing a fire in the room used by resident to smoke.

This action was completed. Inspectors observed a fire blanket and fire extinguisher in the designated smoking room.

20. Action required from previous inspection:

Ensure that all complaints are recorded, managed in accordance with policy and the outcome agreed with the complainant in a timely manner.

Inspectors observed the complaint log and the person in charge had recorded the details and outcome of a complaint made and not recorded at the previous inspection. However, this is still not in line with centre policy which clearly states that the person receiving the complaint must record it on the complaint form and pass this on to the person in charge as soon as possible to the event. The policy also states that the complainant will be given a complaint form to complete should they so wish. The details of further complaints and actions taken by the person in charge were available but the views of the complaint on the outcome were not recorded.

21. Action required from previous inspection:

Put in place procedures to ensure that the reasons for administrating of sedative medication on a pro-re-nata (PRN) basis are supported by clear guidelines.

Inspectors found that progress commenced on the previous inspection in relation to a review of medication and in particular the use of psychotropic medication was continuing.

22. Action required from previous inspection:

Provide written evidence that all the requirements of the statutory fire authority have been complied with.

Implement all the requirements of the fire risk assessment report.

Provide adequate training for staff in safe fire management procedures and evacuation of residents.

The provider remains unable to supply written confirmation from suitably qualified person that all the requirements of the statutory fire authority have been complied with. Priority 'A' fire works which were initially due for completion in September 2010 and subsequently November 2010, have not been completed by this date of 20 July 2011. These priority works included the installation of appropriate fire doors to allow compartmentalisation and subsequent safety of residents in the event of a fire. The local area fire officer confirmed for the Authority that these works have not been undertaken.

However, the completion of these priority works will not result in the provider been able to produce the required written evidence of compliance as a significant amount of work remains to be done. The provider had indicated that further fire training for staff would take place in view of the number of new staff employed. This has not

occurred. Inspectors interviewed two newly recruited staff and found that they had been given only cursory advice on the procedure for fire safety and the evacuation of residents. They had not participated in any fire drills.

Report compiled by:

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

25 July 2011

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 additional inspection report*

Centre:	Woodlock Nursing Home
Centre ID:	0305
Date of inspection:	20 July 2011
Date of response:	28 July 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 provider has failed to comply with a regulatory requirement in the following respect: Failure to provide written confirmation from a suitably qualified person that all requirements of the statutory fire authority have been complied with.
Action required: Undertake regular and documented fire drills and ensure that all staff are adequately inducted in fire safety and evacuation procedures.
Action required: Comply with all requirements outlined in the fire risk assessment report.

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

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 provider has always been willing to undertake the works necessary to make the premises fire safe and has been frustrated by the complexity of some items (fire doors), the difficulty in raising finance in the current climate and most recently, the issuing of the notices by the Authority in June which all have had a negative impact on the timescale for the work. Fire training has already been carried out with staff and the provider is arranging further training to be carried out on future dates. The provider has always kept the fire officer regularly updated on our progress. Pending the completion of the works, an enhanced program of fire safety management was implemented in agreement with the fire officer. This includes regular inspection checks on all doors along the escape routes every hour during the night which are documented, time recorded, signed, and spot checked by the provider against the security cameras. Our intention here is to have the fire doors and any training required completed by the given date, but this is heavily dependent on the outcome of the notices/appeal as all capital expenditure is on hold pending a satisfactory outcome.	30 October 2011

2.The provider has failed to comply with a regulatory requirement in the following respect: The provider employed a person in charge who does not hold the experience required by the regulations to hold the position.
Action required: Ensure that there is a person in charge who has a minimum of three years experience in the area of geriatric nursing within the previous six years.

Reference: Health Act 2007 Regulation 15: Person in Charge Standard 27: Operational Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The provider is well aware of the requirement under legislation for the person in charge. However, after numerous attempts via agencies and advertisements, the provider has been to date unable to source a person with the required experience. Ms Fitzgerald was appointed in a temporary capacity to enable the provider to continue the search for an appropriate person. Despite her not fulfilling the required geriatric experience, she is a very highly qualified and experienced nursing professional and has had a very wide range of experience in all areas of nursing care including geriatric. She has over 20 years experience in senior nurse management with an MBA in Health Services Management. The reference for the person in charge referred to is now available; however, the reason for this delay was very clearly explained to Ms Noelene Dowling, lead inspector at the fit person interview and at each subsequent inspection visit. The reason for the delay was awaiting the outcome of an employment appeals process which is now complete. This reference has now being sought by the provider and will be forwarded once received to the Authority. The recruitment of an appropriately experienced person in charge is an ongoing process and has been since January 2011. As such, we are unable to give a definite timescale at this stage for it to be completed.	Ongoing

3. The provider has failed to comply with a regulatory requirement in the following respect: There was no adequate arrangement in place for when the person in charge was absent from the centre.
Action required: Put in place an adequate system of management when the person in charge is absent from the centre.

Action required: Ensure that the appointed person is facilitated, by means of duty hours and delegated responsibilities to engage effectively in the tasks of governance.	
Reference: Health Act 2007 Regulation 15: Person in Charge Standard 27: Operational Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: In view of the change in the person in charge and other staff changes and reorganisation, it was important that the decision of the key senior manager not be taken until a proper evaluation had been carried out. This matter has now been dealt with and the provider has now appointed an acting key senior manager who will deputise during absences of the person in charge, with effect from the 25 August 2011. An NF31 Change in Key Senior Management Personnel pack is currently being completed and will be forwarded to the Authority in due course.	Completed

4. The provider has failed to comply with a regulatory requirement in the following respect: Failing to have a comprehensive centre-specific written risk management policy in place and implemented throughout the designated centre.
Action required: Ensure that the risk management policy covers the precautions in place to control the following specified risks: ▪ the unexplained absence of a resident ▪ assault ▪ accidental injury to residents or staff ▪ aggression and violence ▪ self-harm.
Action required: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents and take appropriate actions to remedy findings.

Action required.

Implement an adequate emergency plan.

Action required:

Implement adequate health and safety audits of the premises.

Reference:

Health Act 2007
Regulation 31: Risk Management Procedures
Regulation 30: Health and Safety
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The risk management policy is being reviewed and will be completed in two months. Due to the large amount of policies and care plans been updated at the moment, it is important that adequate time be allowed to ensure that they are as fully comprehensive and centre-specific as possible. Our emergency plan is being further developed and will be reviewed within two months. The person in charge is currently arranging for a health and safety audit (including risk assessment) to be carried out.	30 September 2011

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

Failing to ensure that appropriate and suitable practices relating to the administration of medicines to residents are implemented.

Action required:

Ensure that residents have access to required medications in a timely and effective manner.

Action required:

Ensure that the practice in relation to ordering, prescribing and administration of medication is in line with An Bord Altranais Guidelines 2007 and circumstances where errors may occur are identified and promptly addressed.

Reference:

Health Act 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management
Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The person in charge is discussing with the GP and the pharmacist on how best to achieve a shorter time span from when the GP sees the resident and the issue of the prescription to the pharmacist, therefore to ensure prompt access and delivery of new medication prescribed. The issue of MDA drugs has been addressed with the pharmacist by the person in charge and all MDA scheduled drugs are now being issued with the resident's name.	16 September 2011

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

Failing to provide sufficient and appropriate nursing care at end-of-life to ensure residents comfort.

Action required:

Ensure that residents are supported with sufficient and appropriate nursing and other care at end-of-life having regard to the nature of their needs.

Action required:

Ensure that there are written operational policies and protocols in place and implemented for residents end-of-life care.

Reference:

Health Act 2007
Regulation 14: End of Life Care
Regulation 6: General Welfare and Protection
Standard 16: End of Life Care

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We would absolutely refute that there was any failure to provide sufficient and appropriate end-of-life care as mentioned in the report. The failure was solely that of nursing staff not recording adequately the steps carried out. Moreover, we would contend that the assertion in the action plan above of "failing to provide sufficient and appropriate nursing care at end-of-life to ensure residents comfort" presents an extremely misleading and biased picture and it is also an unfair reflection on staff, who have been constantly praised by both residents and relatives for the standard of care they have been providing. To assume because of the omission of entries in the nursing records and in the absence of any other indication that there was what would have amounted to gross negligence, callousness and inhumane treatment of a dying resident is totally beyond comprehension and displays a total lack of balance, fairness and professionalism in the presentation of the report. Like all our policies, the end-of-life policy is also being refined at present, using the Liverpool model, to be more centre-specific and more frequent notations will be specified. The end-of-life care plan is being adapted to be centre-specific and the education of staff on documentation procedures is being addressed. We have examined the notes of the resident who died and the file reviewed by the inspectors. The decision not to resuscitate had been made by the resident in conjunction with the consultant in WRH. Following a hypoglycaemic episode, the consultant was contacted by the person in charge and she advised that the resident be transferred to WRH. The ambulance was called but the resident refused to go. The locum GP was called to talk with the resident regarding her wishes and communicated by phone with the WRH consultant. The homecare team were contacted and the wishes of the resident were respected. The family were called and were in attendance and reassured that the resident's wishes would be followed. The homecare nurse also came, and together with the GP reviewed the resident and explained to the resident the plan of care based on symptom management. As it was a Friday, all medication that may be required over the weekend by the homecare team was received should the resident require pain relief and all this was explained both to relatives and resident. The resident's condition remained unchanged on the Saturday. On the Sunday morning, the resident was checked by the nurse on day	30 September 2011

duty and the care assistants approximately 10 minutes before the resident passed away. The documentation on Saturday night and Sunday morning did not reflect accurately the end-of-life care provided. The person in charge has spoken to all nursing staff concerning not only documentation as regards end-of-life care but all documentation pertaining to the resident. The person in charge is working with the nursing staff on a suitable care plan, incorporating the multi-disciplinary team but also to ensure that residents receives all appropriate care with dignity at the end-of-life.	

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

The care plans did not provide adequate assessment of residents needs and were not

- evidence-based
- monitored effectively to ensure suitable and sufficient care to maintain the residents welfare and wellbeing
- contained no evidence of consultation with resident or relatives.

Action required:

Ensure that each resident's care plan is monitored effectively and consistently by continuous assessment using recognised and evidence-based assessment tools.

Action required:

All assessments/ monitoring tools including weight and fluid intake necessary must be consistently applied, adequately reviewed and interventions made as required by this review.

Action required:

Ensure there is consultation with residents and or relatives in relation to care plans.

Reference:

Health Act 2007
Regulation 8: Assessment and Care Plan
Regulation 6: General Welfare and Protection
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Work on the care plans is ongoing and includes consultation with relatives and residents. The Barthel dependency index has been commenced for all residents and will be reviewed on a monthly-basis or as required. The person in charge is currently reviewing the dietary and fluid intake of all residents and is being developed in conjunction with the dietician. Fluid balance charts are being reviewed with a plan to have a more simple combined system to address fluid and nutritional monitoring of all residents. A further page has been added to the dietary intake form introduced in conjunction with the dietician. This records all fluid intake for all residents. This is an ongoing process and is being monitored by the person in charge.	30 October 2011

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

Practise in relation to the assessment of need and consent for the use of methods of restraint remain inadequate.

Action required:

Ensure that policy on the use of any methods of restraint is evidence-based, centre-specific and implemented in practice.

Action required:

Put in place and implement policy on adequate assessment for the use of any method of restraint and the seeking of informed consent for such usage.

Reference:

Health Act 2007
Regulation 8: Assessment and Care Plan
Regulation 31: Risk Management Procedures
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The usage of bedrails is being reviewed at present. No other restraints are in use.	30 September 2011

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

There was inadequate evidence that the assessment carried out when an incident of abuse occurred was satisfactory to the relevant external professionals with responsibility for safeguarding older people.

Action required:

Ensure that assessments carried out are sufficient and satisfactory to the relevant professional and safeguarding personnel in order to ensure there is no further risk to residents.

Reference:

Health Act 2007
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 31: Risk Management Procedures
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The incident of alleged abuse at this centre has been fully reviewed by the appropriate personnel (the resident's general practitioner, social worker, person in charge and local Gardaí). The social worker for elder abuse has tried to contact the superintendent of the local area to include his input and is awaiting a reply. All correspondence to date has been forwarded to the Authority and the most recent email correspondence from the social worker for elderly care was reviewed by Ms Noelene Dowling, lead inspector during the unannounced inspection visit of the 24 August 2011. Protective monitoring will remain in place. The policy on elder abuse was taken from national guidelines and	16 September 2011

will be further adapted to be more centre-specific. Training in elder abuse has taken place on 14 March 2011, 28 March 2011 and 10 August. A total of 29 staff have attended and further training has been offered in future dates an ongoing process. The provider is committed to act according to best practice and regulation when incidents occur.	

10.The person in charge has failed to comply with a regulatory requirement in the following respect: The numbers and skill-mix of staff were not appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
Action required: Ensure that there are a sufficient number of nursing staff employed and available to meet the needs of the residents' on a continuous basis and ensure adequate arrangements for emergencies and contingencies are in place.	
Reference: Health Act 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The number of nursing staff is now seven whole time equivalents as one member of staff has returned from maternity leave. There is an ongoing recruitment process in motion to attract more candidates. In a small nursing home, it is sometimes necessary for the person in charge to cover nursing shifts during exceptional circumstances, for example, compassionate leave and sick leave. Also, in this instance it was deemed safer than to employ agency staff to work amongst recently recruited nurses. The person in charge has resumed full time to management duties and this has been augmented by the appointment of the acting key senior manager, who will have protected management hours to work with the person in charge in further developing policies and implementing them. A formal induction/orientation programme is being developed by the person in charge and acting key senior manager and is to be in	16 September 2011

place within two weeks. Staff will be rotated to work with the newly appointed acting key senior manager. The results will provide feedback for the appraisal process.	

11. The person in charge has failed to comply with a regulatory requirement in the following respect: Staff members did not have access to education and training in areas of practice which meet the needs of the current resident profile.	
Action required: Ensure that staff members have access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Action required: Ensure staff have adequate induction prior to undertaking direct care with residents.	
Action required: Arrange for the adequate supervision of staff on an appropriate basis pertinent to their role and taking account of any deficits or incidents which indicates additional supervision or appraisal is necessary.	
Reference: Health Act 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Mandatory training is being addressed with manual handling, patient handling and CPR training having occurred to date. Elder abuse training has taken place on three occasions and further training is planned. Dementia training is scheduled for 12 September 2011. One staff member has been booked to commence Sonas training on 7 October 2011 and 11 November 2011, the reason for the delay was no places were available on the previous course. A process of staff appraisal with staff nurses has commenced with 50% of nurses complete. Following review of nursing staff, the appraisal process will be rolled out to all other staff grades to	Ongoing

identify strengths, weaknesses and training needs. All staff are continually rotated between night and day.	

12. The provider has failed to comply with a regulatory requirement in the following respect: Essential equipment necessary for residents' safety and wellbeing was not suitable, and maintained in good working order and replaced in a timely manner.	
Action required: Install a call-bell system which is suitable for purpose and ensure that it is accessible to residents.	
Action required: Replace the dishwasher to prevent infection and risk to residents.	
Reference: Health Act 2007 Regulation 19: Premises Regulation 30: Health and Safety Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The provider is arranging for a service of the existing call system. The new dishwasher was ordered and due for install before the end of June, however, this was delayed because of the receipt of the notices from the Authority. Whilst the provider, and indeed the supplier, would like to see this installed as soon as possible, the timescale cannot be definite with the notices/registration issue pending. Our intention here is to have the dishwasher completed as soon as possible and in advance of the given date, but this is heavily dependent on the outcome of the notices and appeal as all capital expenditure is on hold pending a satisfactory outcome.	30 September 2011

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

There is no system for reviewing the quality and safety of care provided to and the quality of life of, residents in the designated centre at appropriate intervals.

Action required:

Conduct a formal review of the quality and safety of care provided to residents or use of information collated through record keeping to improve high risk areas.

Action required:

Utilise data collated to manage clinical and health and safety risk to improve resident outcomes.

Action required:

The person in charge for the purposes of ongoing quality monitoring and continuous improvement collects data on:

- residents who have been physically restrained within the previous week
- residents who have fallen within the last month
- residents who have experienced significant weight loss
- complaints
- residents who have received psychotropic drugs (including sleeping tablets).

Reference:

Health Act 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Quality of patient care audits are already being carried out in a systematic process and the required information is being recorded and will be kept on a database and regularly reviewed in conjunction with other members of the healthcare team such as the dietician, physiotherapist and the residents' general practitioners.	30 October 2011

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

There was no adequate procedure for the recruitment, selection and vetting of staff.

Action required:

Put in place recruitment procedures to ensure no staff member 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 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: 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 forms and medical declarations.	Ongoing

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

The premises is unsuitable for the purpose of achieving the aims and objectives set out in the statement of purpose.

Action required:

Ensure that all sinks and equipment are adequately maintained and in working order.

Action required:

Provide sufficient numbers of toilets, and wash-hand basins, baths and showers at appropriate places in the premises.

Action required:

Provide a sufficient number of toilets which are designed to provide access for residents in wheelchairs, having regard to the number of residents using wheelchairs in the designated centre.

Action required:

Provide adequate sluice facilities.

Action required: Make the driveway and grounds safe and suitable for use by residents and relatives.	
Action required: Put in place an adequate program for routine and suitable maintenance of the building and a plan for renewal of fabric, decoration, furnishings and facilities for residents use.	
Action required: Make safe the internal balcony to ensure it does not present a risk to residents' safety.	
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Repair work on the avenue was carried out twice over the winter months. However, because of long and persistent cold spells last November 2010 and January 2011, there was further frost damage to the avenue. This has been repaired again recently in June 2011. A bedpan washer had been ordered for installation in the refurbished sluice room, but like the dishwasher, capital expenditure is temporarily on hold following receipt of the notices from the Authority. Our intention is to have the sluice facilities completed as soon as possible and in advance of the given date, but this is heavily dependent on the outcome of the notices and appeal as all capital expenditure is on hold pending a satisfactory outcome. Two main bathrooms have already been updated. Maintenance staff are employed by the provider to carry out ad hoc maintenance tasks and a detailed program of work will be identified and be supervised by the provider. This will include, but not inclusive to the sinks, toilets etc mentioned above. The height of the internal balcony over the stairway has been raised. It had to be done in such a way that didn't interfere with	30 October 2011

or damage the existing balcony due to Woodlock House being a protected structure. The health and safety/risk audit being currently organised will further address this issue.	

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

Practice in the management of complaints remains inadequate.

Action required:

Implement a system for the resolution of complaints in line with centre policy and which details the outcome of the complaint and whether or not the complainant was satisfied with the outcome.

Reference:

Health Act 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A complaints form as per our policy that has being developed and details presently being offered in complaints book, which was inspected by the inspectors on the 24 August 2011	30 September 2011

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

Relatives or visitors are effectively restricted from accessing the premises by the provider's failure to implement an adequate system for allowing access and answering the door bell in a timely manner.

Action required:

Ensure that relatives or visitors to resident have access to the premises and residents in a timely manner without undue restrictions.

Reference:

Health Act 2007
Regulation 12: Visits
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Reception is manned during the day from 12:30hrs up to 20:30hrs at night during the week and an additional care assistant is rostered at the weekends to cover the doors and phones. It is planned by the provider to upgrade the main door to give biometric access to relatives outside of normal office hours. It is unfair to say in the report that there is "effectively a restriction of visiting times" as that is not the case. It has been highlighted to the inspectors on each of their inspection visits that 10 of our residents are 90 years of age or older and a further seven are 85 years or older. They like to go bed early in the evening and it is unfair on these residents to have visitors up and down the stairs and walking about the home when they are trying to sleep. It is after all our resident's home. A complaint was received recently through the Authority that a relative was waiting outside to gain access for an inordinate length of time on one specific evening. However on review of the closed-circuit television (CCTV) and speaking with staff on duty on that date revealed that there was only one relative who entered the premises during the time in question and he entered and left without any problem or delay as can be verified by the CCTV record.	Ongoing

18. The provider has failed to comply with a regulatory requirement in the following respect: Not providing adequate and centre-specific policies and procedures as required by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).
Action required: Ensure that the policies available are accurate, centre-specific and are implemented in practice.
Reference: Health Act 2007 Regulation 27: Operating Policies and Procedures Standard 27: Operational Management

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Work on developing centre-specific policies and procedures has been ongoing and will continue until we are satisfied it is sufficiently comprehensive.	30 October 2011

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

To notify the Chief Inspector of accidents or incidents occurring in the centre.

Action required:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre as specified in the regulations.

Reference:

Health Act 2007
Regulation 36: Notification of Incidents
Standard 8: Protection
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: There was no accident or incident that was not reported and we assume here that this referred to the quarterly notifications. It was an oversight at the end of July that the quarterly notifications were not submitted at the end of July when due. We will ensure that these are completed on time in future, as well as any other notification required. Any grade one and grade two pressure wounds will be notified by the person in charge immediately.	Ongoing

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 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 guidance and agreement of specific parameters from 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: 27 August 2011