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:	Willowbrook Nursing Home
Centre ID:	0112
Centre address:	Borohard Newbridge Co Kildare
Telephone number:	045-431436
Fax number:	045-435899
Email address:	willowbrookhome@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Liam Tedford
Person in charge:	Mick Crossan
Date of inspection:	27 March 2012 and 28 March 2012
Time inspection took place:	**Start-Day 1:** 09:50hrs **Completion:** 17:00hrs **Start-Day 2:** 09:45hrs **Completion:** 16:45hrs
Lead inspector:	Noel Sheehan
Support inspector:	Gerard P Mc Dermott
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. These 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

Willowbrook is a 1940s two-storey domestic house and was first established as a nursing home in the 1980s. The current providers took over the service in 2006. The original building has been extended to provide 63 residential places. The provider had recently reduced by six places and Willowbrook currently provides 57 places for male and female residents over 18 years of age, including people with dementia. The main entrance is located on the ground floor. It has a spacious bright reception area which has comfortable seating and pleasant décor. The person in charge has an office which is located behind the reception desk. There is a stairway on the left of the reception desk. Administrative offices, a meeting room and a storage room are situated on the first floor. This is a secure area accessible only to staff which has a key-pad lock. There is a spacious sitting room adjacent to the reception area. The reception area leads onto a corridor and accommodation for residents is provided in two wings, St Anne's on the left, and St Mary's situated straight ahead. The nursing office and staff room are located to the right hand side of the reception area.

St Anne's has accommodation for 22 people. It contains ten two-bedded rooms, two single bedrooms, each with wash-hand basin, and one single en suite bedroom with wash-hand basin, toilet and shower. There are two communal assisted toilets and an assisted shower with an assisted toilet and a communal bathroom with a bath, and an assisted toilet and wash-hand basin. A sluice room is also located in this area. St Mary's wing has accommodation for 13 people. It contains four single bedrooms with en suite wash-hand basin, toilet and shower. There are three single bedrooms and three two-bedded rooms, all with a wash-hand basin, a communal toilet and a communal bathroom with bath, assisted toilet and wash-hand basin. There is a sluice room, store room and boiler room.

The dining room is located directly opposite the reception area and the main kitchen is adjacent to it. There is a lounge area and an enclosed smoking room located at the end of one wing which is connected to the original 1940s house by a link corridor.

The ground floor of the original house provides accommodation for 16 residents. It consists of six two-bedded rooms and two single bedrooms each with a wash-hand basin. There are three toilets and two assisted bathrooms with shower, toilet and wash-hand basin. There is also a storage room and sluice room.

The first floor is accessible by stairs and a chair lift. It provides accommodation for eight residents in four two-bedded bedrooms, each with wash-hand basin. There is a bathroom with a shower, a toilet and a wash-hand basin on the alcove just off from the stairway. There is a second set of stairs with five steps which leads to the four two-bedded bedrooms.

The centre is situated on a spacious site and there are well maintained lawns to the front, side and back of the building. There is CCTV camera coverage inside and outside. There is ample car parking at the front of the building.

Location

The centre is located on the N7 within a five minute drive from Naas and Newbridge, Co Kildare.

Management structure

Liam Tedford is the owner and the Provider. The Person in Charge is Mick Crossan and he reports to the Provider. The senior staff nurse is Denyse Chaney who reports to the Person in Charge. Nurses report to the senior staff nurse and care assistants report to the nurse in charge. The kitchen assistants report to the Chef who reports to the Head Chef who in turn reports to the Person in Charge. The laundry and catering staff report to the housekeeper who reports to the Person in Charge. Maintenance and administrative staff report directly to the Provider.

Background

This was an inspection to enquire into an incident in which a resident was severely injured as a result of burns sustained in Willowbrook Nursing Home on 23 February 2012. As required by Regulation 36 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), the person in charge of Willowbrook Nursing Home has given notice to the Chief Inspector of a serious injury to a resident on 23 February 2012. The information received related to the injury of a resident as a result of severe burns sustained while the resident was smoking in the grounds of Willowbrook Nursing Home. The resident was taken from Willowbrook Nursing Home on 23 February 2012 to Naas General Hospital where she passed away on 24 February 2012. The injured person had been a resident in the centre since February 2010. Initial contacts had been made by inspectors to ascertain more detailed information regarding the event, risk management procedures and particulars of the injured resident prior to the inspection.

Summary of findings from this inspection

This was an announced inspection. Inspectors formally interviewed the provider, the person in charge and all staff who had contact with the injured resident on the night of 23 February 2012. A detailed inspection of the garden area and the smoking room was carried out. Documents which included risk management policies, safety statement, care plans, the accident and incident log, complaints log and medical administration records were also reviewed.

The provider is closely involved in the running of the centre and is present there on a regular basis. The person in charge is employed on a full-time basis and is involved in the day-to-day running of the centre. All staff interviewed were committed to

improving the service to residents and all expressed regret at the incident that had occurred.

Risk management information with specific regard to the injured resident and other smokers showed that individual risk assessment in place was adequate, and control measures put in place took into account residents' cognitive and physical impairments.

Staff interviewed, and documentation and record keeping seen by inspectors, demonstrated that the supervision provided was appropriate to residents' actual needs based on the information available at the time of admission and subsequent reassessment.

The provider, person in charge and staff interviewed were cooperative with inspectors, and in many areas of activities, inspectors were satisfied that staff interviewed were competent to ensure the needs of residents were met to a satisfactory standard.

In the intervening four weeks between the incident and the inspection, action had been taken by the provider and the person in charge to ensure that enhanced risk assessment and management procedures were implemented to ensure the safety of residents regarding the activity of smoking in the centre. These measures included; reviewing the incident with the assistance of the fire department of Kildare County Council, the introduction of a more formal and comprehensive assessment of safety measures for each smoker, this had been discussed with each resident and/or their relatives. Smoking aprons and fire blankets were purchased and installed, further risk assessment group meetings took place which identified the need to update the smoking policy and reflect these changes in the centre's overall risk assessment policies.

A feedback meeting was held between the inspectors and the person in charge at the end of inspection. At the feedback meeting a discussion place took regarding the practicality of provision of smoke retardant clothing and achieving a balance between a resident's choice to smoke and ensuring reasonably practicable fire safety management practices.

The Action Plan at the end of the report identifies areas where improvements were required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the National Quality Standards for Residential Care Settings for Older People in Ireland. These improvements included, for example, the compilation of a comprehensive written statement of the precise risk controls that have been put in place regarding residents who smoke; ensuring that risk control measures set out in the relevant policies and procedures are reflected in practice; ensuring that recorded staff checks on residents on the night shift are as reflected in documentation; when duties other than resident supervision take place during the night shift e.g. laundry, this should be reflected in staff rotas and resident checklists and taken into account regarding staff levels on duty.

Issues covered on inspection

1. The enclosed garden area and smoking room:

The garden area where this incident occurred is bounded by the nursing home building, laundry and fencing on two sides. The garden is visible from the dining room, activities room, smoking room, laundry and two bedrooms. The enclosed garden area is provided with outdoor furniture, stand-up ash trays and well maintained lawn and flower bed areas. Inspectors were told that the injured resident routinely smoked outside in the enclosed garden, which was located approximately ten meters from her bedroom, where she liked to sit on the wall surrounding a raised flower bed.

The smoking room measures five meters by four meters approximately and is located directly beside the main day room and is clearly visible through a glass partition wall. The smoking room is provided with a heat detector, fire extinguishers, fire blanket, break glass unit and fire door to the garden. The smoking room also has a CCTV camera installed which is monitored from the reception area and the nurses' station. The smoking room is serviced by both natural and mechanical ventilation. At the time of the incident the smoking policy had identified the smoking room as the designated smoking area for residents and was the only area of the centre where smoking was permitted. Inspectors observed that protective covers for smokers had been provided for the use of some residents. Inspectors were told that these had been purchased since the 23 February 2012 and were designed not to ignite and to give protection to prevent ignition of clothing. On the days of inspection, Inspectors observed that the smoking room was used by residents throughout the day and once finished their cigarette they would return to the day room. Staff use a smoking area that is identified in the smoking in the workplace policy as the back yard area.

2. Risk assessment and management of resident smoking:

Risk assessment and management information regarding smoking in the centre was available within the following documentation given to inspectors:

- the centre's operating policies and procedures which specifically addressed residents' safety issues such as care of the resident with dementia, wound care management and responding to challenging behaviour, fall prevention and fire safety
- the site-specific health and safety statement for the centre
- the fire safety register that referred to the overall safety of residents and staff in the centre
- Individual residents' care plans that referred to individual risks.

There was no single, overarching risk management policy; however, an extensive range of clinical and environmental risk management material was included in the Willowbrook Nursing Home operating policies, and referred to areas such as pain

management, challenging behaviour, infection control, fire, missing person etc. The policy on smoking in the workplace noted that it was the policy of Willowbrook Nursing Home to: “ensure that with the exception of the residents smoking room, all other areas of Willowbrook Nursing Home are smoke free areas” and that “anyone found smoking in the nursing home, with the exception of residents in the residents smoking room will be requested to refrain from same”. The persons identified as responsible for implementing this policy was the director of nursing. The policy on maintenance states that: “The residential care setting provides, where possible, a safe outdoor space with seating, accessible to all residents including residents with mobility impairments and those using wheelchairs. The grounds are kept safe, tidy and attractive. There is a secure area for people with dementia”. There was an emergency plan in place which was last updated on 26 March 2012 and detailed important contact phone numbers, procedures to be followed in the event of a fire and evacuation procedures for ambulant, semi-ambulant and non-ambulant residents.

The health and safety statement dated July 2010 was comprehensive and identified specific risks and controls. This documentation covered the employer’s duty of care to staff, residents and visitors. Resident specific safety controls did not come within the remit of this documentation. A number of specified risks such as manual handling, slips, trips, and falls and legionnaires disease were addressed in separate hazard identification sheets. This policy identified carelessly discarded smoking materials as a risk and as a control measure stated that “there is an area for smoking here”. “This area is carefully monitored for fire safety”. The risk groups identified were all staff, contractors, visitors and residents.

A fire safety register was available in which there was evidence of fire drills being conducted on a monthly basis. Frequent and up-to-date checks were documented on the maintenance of fire safety equipment (monthly and annual), emergency lighting testing and maintenance (quarterly), fire alarm tests (weekly), fire resisting and exit doors (daily) and periodic testing and maintenance of fire extinguishers by a contactor. Documentation showed that fire safety training, delivered by a fire consultancy firm, had been attended by 48 staff members in April 2011, including all five staff members on duty at the time of the incident on 23 February 2012. The policy on fire was comprehensive and detailed the location of fire escape exits, break glass units, fire blankets, fire extinguishers, fire zones and the fire panel. This policy also detailed the actions to be taken in the event of a fire.

3. Individual risk assessment and care planning:

Inspectors were told that information regarding individual assessments of residents was available in the individual care plans. The person in charge said that there was no formalised risk assessment in place regarding residents smoking, however, in his opinion the procedures in place did ensure an adequate assessment of risks. All of the nursing and care attendant staff interviewed indicated that they were of the opinion that assessment of smoking was adequate to ensure resident safety. The injured resident’s care plan and the care plans of other smokers showed that control measures put in place took account of residents’ individual cognitive and physical impairments.

The injured resident was first admitted to Willowbrook Nursing Home in February 2010. Information referred to in the resident's assessment of needs included; malnutrition universal screening tool; oral cavity assessment guide; waterlow pressure sore prevention; and continence assessment. In terms of mobility the resident was assessed as 'medium dependency' and used a walking aid since undergoing a right hemiarthroplasty in August 2011. Information recorded in her care plan related to care need/problems, proposed aim of care, nursing interventions, date of reassessment of care plan, date and time of care plan creation, and signature of staff member and resident. The care plans also noted residents choices and preferences. Inspectors examined the injured resident's care plan and saw that it was originally drawn up on 12 February 2010 and was reviewed and updated every three months. The care plan was last reviewed on 20 February 2012. Specific information for the injured resident related to the need for appropriate stimulation and activities, falls risk, nutritional intake, continence, level of mobility, maintenance of independence, positive self image, maintenance of physical and psychological safety, communication, pain management, medication, and, activities of daily living. It was noted that the resident was a smoker and that she was aware that smoking was only permitted in the designated smoking area. It also noted that she needed to be monitored to make sure that she followed the in-house regulations regarding smoking in order to provide for her and other residents' safety. The injured resident was commenced on nicotine patches by her GP in November 2011 however this course was discontinued in February 2012.

Varying individualised risk controls are identified in the care plans of other residents who smoke. Some smokers hold onto their own cigarettes and lighter, while others are deemed to be unsafe with lighters. It was identified in the care plans and at staff interviews that some residents require more observation than others.

4. Incident reporting:

The providers and person in charge promote a culture of health and safety of residents. There was evidence that the registered provider and person in charge had put in place arrangements for learning from this serious event. There was a comprehensive system of accident and adverse incident reporting. No incidents relating to the activity of smoking or burns were noted except the incident on 23 February 2012. There was evidence of analysis and a process of learning from the recorded information regarding adverse incidents such as falls. Inspectors were told that incidents were discussed with staff through handover meetings. Staff reported that the incident of 23 February 2012 was discussed at hand over and staff nurse meetings, care assistant meetings and joint meetings, this was supported by documentation seen by the Inspectors. Weekly governance meetings are held which address the subject of risk management. Since the incident on 23 February 2012 a number of meetings had discussed enhanced risk controls for residents who smoke for example, the purchase of smoking aprons, and, more comprehensive smoking risk assessments for individual smokers. New risk control measures regarding residents smoking and balancing safety with individual rights and choices were discussed with residents and families individually and at a residents committee meeting.

Staff interviewed said that they never had any concerns regarding residents who smoked and had not observed any burns on clothing or risky behaviour on the part of the injured resident such as dropping a burning cigarette or lighter previous to the incident on 23 February 2012.

The complaints log was examined by inspectors, no record of complaint or communication was seen regarding residents smoking in the centre. In the nursing notes of residents who smoked in the centre it was noted that communication with relatives or other visitors regarding any concerns they may have had about residents smoking were not recorded.

5. Staff training and competencies:

Inspectors formally interviewed seven persons, which included the provider, the person in charge and all staff who had direct contact with the injured resident on the night of 23 February 2012. Interviews concentrated on staff knowledge and contact with the injured resident, length of time in post at Willowbrook Nursing Home, staff experience of provision of suitable and sufficient care to the injured resident and other smokers in the centre, staff qualification, and competence and issues in relation to dependency assessment and staffing levels. Knowledge of risk issues and the smoking policy were also covered. At the close of the interview each interviewee was given an opportunity to add anything that they would consider relevant but had not been covered during the course of the interview.

All staff interviewed were open and cooperative. There were examples of good practices and there was a sense of staff working well together, being well supported by the provider and the person in charge with the outcome for each resident a priority. Staff members said they were happy with their work and talked about feeling valued. Staff could clearly outline their roles and responsibilities and they said that they reported all issues to their line manager who reported to the person in charge.

There were staff induction, probation and appraisal processes in place. Staff reported good access to the person in charge. The person in charge has been in place in this centre since 2002.

A training plan was in place for all staff. Training was divided into what was mandatory and what was specific to particular staff member's e.g. mandatory training for all staff included manual handling and fire training. Specific training for all staff included management of challenging behaviour and dementia care. All staff nurses had undertaken medication management, up to date CPR and first aid training. A number of care staff had undertaken the Further Education and Training Awards Council (FETAC) Level 5 qualifications. The five staff on duty at the time of the incident had all undertaken CPR training.

Nurses' current certificates of registration with An Bord Altranais were viewed by inspectors and were up-to-date and available for all nurses working in the centre. A majority of staff interviewed have worked in the centre for more than two years. A good skill-mix was noted. Inspectors noted that staff turnover was low.

During interviews inspectors sought to clarify with the provider, the person in charge, and staff, their awareness of procedures and control measures in place regarding residents smoking. Inspectors were told by the person in charge that the centre's policy was that smoking was confined to the smoking room only, as referred to in the centre's operating policies and the safety statement, however, that the injured resident preferred to smoke outside in the enclosed garden, which was located approximately ten meters from her bedroom, while sitting on the wall surrounding a raised flower bed. The person in charge explained that she was a very private person who did not like to use the inside smoking area. The person in charge also referred to information in the injured resident's assessment and care plan which showed that her needs were kept under review by nursing progress notes, nursing assessments and evaluation of care plans on a three monthly basis or sooner as required. The person in charge said that the injured resident was assessed and closely observed regarding her capability to safely manage her smoking habit in the first week after admission to the centre. The person in charge then referred to other residents' care plans and gave examples of risk controls put in place for other residents who were identified as posing a high risk due to cognitive or physical impairments. Interviews showed staff awareness of the other residents who smoke and the varying degrees of risk identified in the care plans, for example staff were able to indicate some residents who smoked that are capable of safely holding onto lighters and cigarettes while other residents needed more supervision and observation.

The person in charge and staff all said that the injured resident's capacity for decision making was good and that she was of an independent mind, was capable of managing her own smoking habit, and had never displayed any reason that gave cause for concern before the incident on 23 February 2012.

6. Staffing arrangements and resident supervision.

Staff are placed on the rota from 08:00hrs to 20:00hrs (day shift) and 20:00hrs to 08:00hrs (night shift). There were two staff nurses and three care assistants on duty at the time of the incident on 23 February 2012. The inspectors viewed a rota for the week of 23 February 2012. The provider and person in charge were of the opinion that there were sufficient staff on duty to meet the needs of the residents and that staff on duty at the time of the incident on 23 February 2012 were knowledgeable about the needs of all residents. Each nurse worked with a carer and was assigned responsibility for named residents during the night shift. Each nurse administered medications for residents in their care. This meant that residents were supervised by a nurse and a carer in each part of the building during the night. The person in charge referred to a validated dependency tool which had been used to determine the staffing and skill-mix required to meet residents' needs based on their dependency, the organisation of care and the size and layout of the building.

At the time of the incident on 23 February 2012 one nurse and one care assistant were allocated to both the front of the building and rear of the building with a twilight care assistant, who was on duty from 6pm to 11pm, available to assist as required. Inspectors were told that there was no formal supervision arrangement in place for the enclosed garden area or smoking room and that staff would look into the enclosed garden area or the smoking room while passing between other tasks.

All of the persons interviewed expressed their satisfaction at the supervision arrangements in place for the supervision of smokers at the time of and since the incident on 23 February 2012. The person in charge described the injured resident as being at 'at risk' because of her wish to keep to herself in the centre. The person in charge and staff interviewed said that the injured resident would have been checked once hourly from 8am to 8pm and twice hourly from 08:00hrs to 20:00hrs. The 'at risk residents hourly checklist' was in place for 21 of the centres 51 residents between 08:00hrs to 20:00hrs. All residents were checked twice per hour according to the 'night restraint checklist' which was in place from 08:00hrs to 20:00hrs. Interviews of the five staff members interviewed who came on duty from 20:00hrs showed that there was contact with the injured resident when she had a cup of tea in her room at approximately 21:00hrs and received her medication at approximately 21:15hrs. Staff said that they had told the injured resident on a number of occasions that smoking was only permitted in the designated smoking area and were aware that she needed close monitoring to ensure compliance with this rule.

The premises have been installed with an extensive CCTV system. The enclosed garden area is surveyed by camera number 7 which is located outside room number 4 and camera 8 which is located outside the dining room door. Inspectors reviewed CCTV footage of the incident from which it appears that the injured resident went out to the garden at 22:10:20 pm. At 22:12:50 two staff members passed the resident on their way to the laundry. In their respective interviews these staff members said that they spoke briefly to the resident and that she was well at this time. Two staff members are seen at the exit door of the laundry from 22:13:10 until 22:19:57 pm. The location of the resident would have been visible from the exit door of the laundry 10 to 15 meters away. The incident was noted at 22:23:49 pm. A member of the nursing staff comes from the main building to the aid of the resident at 22:26:44 pm.

The provider informed inspectors that his understanding was that the injured resident had difficulty lighting her cigarette and got a paper towel from within the building which she ignited and that this led to her clothes catching fire. The person in charge was of the opinion that this was a 'tragic freak accident' and not reasonably foreseeable. The persons interviewed expressed opinions that nothing prior to the incident had given them cause for concern regarding the resident's safety or possible behaviour and they had followed normal and appropriate care procedures. The provider acted swiftly to arrange counselling for staff after the incident and was proactive in telling other residents and their families about the incident. There was evidence from interviews of staff that the response was timely and appropriate in the immediate aftermath of the incident. Inspectors confirmed that emergency services were contacted without delay. Staff interviews indicated that appropriate first aid procedures were followed.

7. Actions regarding residents smoking since 23 February 2012:

The provider responded immediately to the incident by conducting a comprehensive investigatigation and had implemented enhanced risk management actions, these included:

While risk assessment was undertaken for each individual smoker prior to the incident, the person in charge had introduced a more formal and comprehensive assessment of safety measures for each smoker. This had been discussed with each resident and/or their relatives. This enhanced risk assessment information was noted in the individual resident's care plans and was understood by all staff interviewed during this inspection. EPIC solutions had been contacted to examine the option of installing the smokers' assessment module of their system. The incident was reviewed with Kildare County Council Fire Department which informed policies and procedures regarding resident safety in the centre. Smoking aprons and fire blankets were purchased and installed. Further risk assessment group meetings took place which identified the need to update the smoking policy and reflect these changes in the centre's overall risk assessment policy. The confinement of smoking to the designated area only and not any area outside the building was also considered. The assessment of risk of flammability of fabric or cellulose-based material, such as clothing or paper towels, which are flammable when in contact with a naked flame, was discussed with residents and their families.

Report compiled by:

Noel Sheehan

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

19 April 2012

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
11 August 2010 and 12 August 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
14 April 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:	Willowbrook Nursing Home
Centre ID:	0112
Date of inspection:	27 March 2012 and 28 March 2012
Date of response:	15 May 2012

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:

The registered provider has failed to ensure that the written risk management policy and procedures that identifies and assesses all risks and identifies the precautions to control the risks regarding residents who smoke in the designated centre were fully implemented in practice.

Action required:

1. Compile a comprehensive written statement of the precise risk controls that have been put in place regarding residents who smoke.
2. Ensure that risk control measures set out in the relevant policies and procedures are reflected in practice.
3. Ensure documentation verifying the above is available at the centre and a copy is provided to the Health Information and Quality Authority.

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

Reference: Health Act, 2007 Regulation 31: Risk management Standard 25: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1) Willowbrook Nursing Home has reviewed, updated and added new operating policies. The Risk Management Policy and Smoking Policy detail precautions taken to prevent risks to smokers. In addition, Olive Safety Services carried out a saftey audit on the 10 May 2012. A new safety statement should be in place before the 28 May 2012. 2) Risk control measures have been discussed at staff meetings and communicated at staff handovers. in addition, a soft copy of the new poilcies has been given to each staff member and they have acknowledged receipt and also their responsibilities. 3) documentation of the above available. Soft copy of policies emailed to Health Information and Quality Authority on the 16 May 2012.	28 May 2012

2. The person in charge has failed to comply with a regulatory requirement in the following respect: The person in charge has failed to make all necessary arrangements which are aimed at preventing residents being harmed.
Action required: 1. Ensure that recorded staff checks on residents on the night shift are as reflected in documentation. 2. If other duties other than resident supervision take place during the night shift e.g. laundry, this should be reflected in staff rotas and resident checklists and taken into account regarding staff levels on duty.
Reference: Health Act, 2007 Regulation 6 (2) (a): General Welfare and Protection Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: 1) As a result of the investigation it appears that the half-hourly checklist is not entirely accurate, particularly between 08:00hrs and 23:00hrs, therefore the twilight (18:00hrs - 23:00hrs) care-assistant is not checking and recording the half-hourly checks between 08:00hrs and 22.30hrs. The remaining four staff record their checks accurately between 23:00hrs and 08:00hrs. 2) The night staff allocation sheet indicates that the car assistants bring cloths to the laundry at 23:30hrs i.e. at a time where all or most residents are in bed. The staff on duty the night of 23 February 2012 informed me that they appeared to be "ahead of schedule and more people than usual were back in bed" and because of this they brought clothes out to the laundry - since advised. The night staff levels were discussed with the inspectors during the previous Authority inspections; as a result the twilight shift (18:00hrs - 13:00hrs) was introduced in December 2010.	Completed

Any comments the provider may wish to make:

Provider's response:

Thank you for your report following your investigation into the tragic events of 23 February 2012.

As you will appreciate my staff and I have found the last few months to be quite traumatic. Apart from our obvious regret at Margaret's death we have reviewed our practices and adjusted/improved them accordingly.

Notwithstanding the fact that the investigating Garda and Fire Officer referred to the incident as a freak accident we do recognise that the tighter the safety measures the more preventable the accident may or may not be. Some factors may make a difference while others may not. For instance, the new formal and comprehensive smokers assessment would still have allowed Margaret to exercise control over her smoking management. The balance between safety and residents choice has been further highlighted as a result of this accident. In addition to the measures already taken, free access to the garden is now restricted to 08:00hrs to 20:00hrs during summertime and daylight hours during winter.

Your report and our old policy correctly stated that the designated smoking area was the smoking room. However the garden was used quite frequently by residents and four standing ashtrays were positioned there. The widespread view was that as an outside space it was also ok as a smoking area. Unfortunately that wasn't stated in our policy. This has now been considered and ammended to be another designated area.

Provider's name: Liam Tedford
Date: 15 May 2012