

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Willowbrook Lodge
Centre ID:	OSV-0000302
Centre address:	Mocklershill, Fethard, Tipperary.
Telephone number:	062 615 60
Email address:	info@willowbrooklodge.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	NSK Healthcare Limited
Provider Nominee:	Noelle Killeen
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	5

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
26 September 2017 07:30	26 September 2017 17:30
27 September 2017 07:30	27 September 2017 15:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 14: End of Life Care	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). Unsolicited information of concern had been received by the HIQA prior to this inspection. This concern alleged issues in relation to care provision including end of life care and medication management practices. However, the inspector found no evidence during this inspection to substantiate these concerns. This unannounced inspection was also conducted to follow up on non-compliances identified at a previous inspection on the 29 March 2017. During this previous inspection there had been significant failings identified in relation to medication management practices. However, on this inspection considerable progress had been made in relation to the 16 actions from the previous inspection. For example, the inspector noted that there had been improvements in the management of medication and there had been a number of actions completed that were aimed at implementing/sustaining these improvements in the center. For example, there had been a full review of nurse medication management practices, targeted training had been provided for all nursing staff, consultations with the prescribing GP's, there had been ongoing meetings with the supplying pharmacist and monthly medication audits had been

completed.

Willowbrook Lodge Nursing Home is located in a rural area approximately seven and half kilometers from the town of Cashel and provided residential services for 26 dependent people. The provider representative informed the inspector that she acquired the center in 2006.

As part of the inspection process, the inspector met with residents, their representatives, staff members, the person in charge and the provider representative. The inspector observed practices and reviewed documentation such as policies and procedures, care plans, medication management, staff records and accident/incident logs. A number of residents stated that they were well cared for by staff, that they were happy living in the center and that they felt safe there. Visitors outlined also that their loved one was happy in the center. The inspector observed that some visitors were on first name terms with some staff and visitors stated that they were always made to feel welcome when visiting. Staff to whom the inspector spoke to were able to demonstrate good knowledge of the residents' healthcare and support needs.

There were 10 outcomes reviewed as part of this inspection, five of the 10 outcomes seven were compliant, four outcomes substantially compliant and one outcome health, safety and risk management was moderately no-compliant with the regulations. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

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

Findings:

On the last inspection improvements were required in the management and staffing resources available to ensure effective delivery of care and services were provided. The provider representative acknowledged that the person in charge had previously not had sufficient protected hours for the role of person in charge and to effectively meet the regulatory requirements of this position. However, during this inspection the inspector noted that protected managerial time of one day a week had been allocated to the person in charge. That there were adequate numbers of staff with the knowledge and skills to meet the needs of residents. The provider representative stated that there was a sufficient bank of nurses available to work in the centre and to cover annual leave or any unplanned absences. That it was only in emergency situation that full time contracted nurses may be required to work beyond their contracted hours. This arrangement was confirmed by staff to whom the inspector spoke. The provider representative stated that there was no issue with staffing at the moment. The person in charge and staff to whom the inspector spoke also stated that staffing in the centre was adequate. This was confirmed by a review of the staffing roster, reviewing residents' dependency profile, speaking to residents and their visitors, reviewing care planning documentation, speaking to staff and review of minutes of staff and management meetings.

The provider representative, the person in charge and the a person participating in management (PPIM) were based on site and met regularly as a collective. Staff who spoke with the inspector were able to demonstrate good knowledge of this management system. There was also a process in place to improve the quality and safety of the service which included undertaking regular audits and structured management meetings. These audits were available to the inspector and included, amongst others: falls, hygiene and infection control, care planning, health and safety, privacy and dignity and medication management practices.

Deputizing arrangements for the person in charge were satisfactory as there was an additional nurse who supported the person in charge in her role and responsibility as PPIM. She also supported the person in charge in the overall governance and management of the centre. The person in charge was in post for the past 19 years and was well known to all residents and staff. The inspector noted that there was a good level of staff supervision and annual staff appraisals were in place. The inspector spoke to staff who explained their areas of responsibility and were found to be knowledgeable and resident oriented, in their approach. Staff to whom the inspector spoke to were aware of the regulations governing the sector and the national standards. Evidence of consultation with residents was available in a sample of care plans reviewed and from minutes of residents' committee meetings. During the two days of this inspection, the inspector noted a number of visitors in the centre. Many residents and relatives spoken with by the inspector were complementary of their experience of care and facilities at the centre. There had been some renovation works completed including the identified issues from the previous inspection. The inspector was informed that resources were available to ensure on going premises upkeep and for the continuous professional development of staff. The annual review of the safety and quality of care had been completed for 2016. The person in charge had made this report available by providing a copy in the main ground floor sitting room.

There was evidence of meetings with staff and regular meetings were held with residents. In this relatively small centre, the person in charge was clearly well known to residents and relatives to whom the inspector spoke with. Many residents were very complementary of care and support provided by staff and the person in charge. From a review of the minutes of residents meetings it was clear that issues identified were addressed in a timely manner and that the person in charge and the provider representative were proactive in addressing any concerns or issues raised. The provider representative was based on site each day and was also well known to residents and was seen positively interacting with many residents who appeared comfortable speaking to her. The provider representative attended the residents' committee meetings and was proactive in responding/addressing any issues raised for example changes to the menu options had been made at one recent meeting and this change to the menu had been immediately facilitated.

There had been significant failings identified particularly in relation to medication management in the previous inspection of March 2017. However, the provider representative and person in charge had made a number of improvements to remedy these failings. These improvements included enhanced medication management vigilance systems including robust oversight and review arrangements, consultation with stakeholders such as the pharmacy and General Practitioners (GP's) to ensure such improvements were sustained. This issue was also addressed under outcome nine of this report. The inspector also noted that where areas for improvement were identified in the course of this inspection; both the person in charge and the provider representative demonstrated a conscientious approach to addressing these issues. Both demonstrated a clear commitment to compliance with the regulations.

Judgment:
Compliant

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Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was an experienced nurse and had worked in the centre for over 19 years. She worked full time in the centre and was a qualified nurse with significant experience in the area of nursing the older person. The person in charge possessed the clinical knowledge to ensure suitable and safe care. During the two days of the inspection, the person in charge demonstrated good knowledge of the legislation and of her statutory responsibilities. She was clear in her role and responsibilities as person in charge and displayed a commitment towards providing a person centre high quality service. The person in charge stated that although she had worked in this centre for many years; she remained very committed to all residents in the centre and to ensuring that they received the best possible care and support. She was fully engaged in the governance and administration of the centre on a consistent basis. The inspector observed that the person in charge was very approachable and for example sat and chatted with many residents at different times during the inspection. She was fully aware of residents' care and support needs, met the night staff each day and attended the daily handover meetings. She also met with all residents on a daily basis and frequently met many residents' representatives. The person in charge had a specific interest in providing a homely environment that was person centred. She explained to the inspector how she promoted continuous improvements in residents' care by for example, continuously updating staff training and had been documenting staff appraisals yearly. Residents, spoken with, described the person in charge as very supportive and staff also confirmed that she a very approachable' manger that had the residents' needs came first in the centre.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

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Theme:

Safe care and support

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

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

Findings:

Unsolicited information of concern had been received by the Health Information and Quality Authority (HIQA) prior to this inspection. This concern alleged issues in relation to alleged poor quality of care provided to residents. However, during this inspection the inspector found no evidence to substantiate these concerns.

There were policies and procedures in place to guide staff in the care and protection of residents. For example, there was a policy on the security of residents' accounts and personal property dated as reviewed in June 2016. There was a policy on the prevention and response to abuse of vulnerable persons at risk which was dated as most recently reviewed in September 2016. There was also a copy of the national "Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures issued by the Health Service Executive (HSE) 2014. The inspector found that there were adequate measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. From a review of the staff training records all staff had received up-to-date training in a programme specific to protection of older persons. This training was supported by the aforementioned policy document on safeguarding which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise.

The inspector reviewed the arrangements in place in relation to the maintenance of residents' day to day expenses and the centre managed a small number of residents financial transactions. The inspector reviewed the system in place to safeguard residents' finances which included a review of a sample of residents' records of monies. The inspector noted that all lodgements and withdrawals were adequately documented or signed for by residents, their representatives and/or two staff. In addition, there were suitable arrangement for a written acknowledgement of the return of the money or valuables and adequate reviewing/auditing of these arrangements. The provider representative confirmed that the financial records were audited to ensure good financial governance was in place. The centre was a pension agent for a small number of residents. In relation to these pension accounts there were transparent arrangements in place to safeguard residents' finances and financial transactions. There was evidence that the provider representative was working with relatives/representatives to arrange suitable accounts for each resident for the management of pension transactions, as soon as possible. However, the inspector noted that improvement was required with the creation of a residents' account separate from the center's in order to be fully compliant with the Department of Social Protection guidelines for pension agents.

There was a policy on meeting the needs of residents with challenging behaviour that had been reviewed in May 2017. Staff were provided with training in the centre on

responsive behaviour (a term used to describe how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). At the time of inspection there was one resident who presented with responsive behaviour. Training records showed that all staff had received up-to-date training in this area. There was evidence that most residents who had presented with responsive behaviours had been reviewed by their General Practitioner (GP) or other professionals for full review and follow up as required. Care plans reviewed by the inspector for residents exhibiting responsive behaviour were seen to include positive behavioural strategies. However, there was insufficient evidence from one care plan reviewed of suitable review/response to emerging clinical information and it was not evident that this information had been effectively used to develop the residents' care plan or inform care practice to address this care need. This issue was actioned under outcome 11 of this report.

On the previous inspection there was improvements required in relation to the provision of supporting policies in relation to the use of restraint. However, the inspector noted that there was a copy of the national policy (HSE) policy December 2011 on the use of restraint and a copy of the HIQA guidance dated October 2014 available for staff. In addition, there was a centre specific policy on the use of restraint which was most recently updated April 2017. There was a low incidence of restraint in the centre and there was evidence that it was used in line with national policy. The restraint register recorded two residents using bedrails and seven residents with bed wedges in place on the days of inspection. From the sample of records viewed; there was evidence for all residents with any form of restraint that there was regular checking/monitoring of residents, discussion with the resident's family, the visiting physiotherapist and the GP. The inspector saw that there was an assessment in place for the use of restraint, which clearly identified what alternatives had been tried to ensure that the particular form of restraint was the least restrictive method to use. For all residents with any form of restraint; there was also a risk assessment completed and the details entered onto the restraint register. These details were reviewed at least every quarter. However, some of these risk assessments were not adequate as some sections of these records had been left blank for example, in relation to the risk assessment result. In addition, the risk assessment forms were prepopulated with the risk quantification at "high" prior to controls being recorded and "low" after controls were implemented for all assessments. This prepopulating of risk assessments could not accurately reflect all risk assessments in advance of controls being implemented and was therefore not always an accurate reflection of the assessed risks. As this issue was also affected other risk assessments completed in relation to residents safety this issue was therefore addressed and actioned under outcome 8 of this report. Overall, the inspector was assured by the practices in place and saw that whenever possible alternative measures were used. For example, there were low-low beds and alarm mats used for a number of residents to reduce the use of bed rails in the centre.

Judgment:

Substantially Compliant

***Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and***

protected.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The provider representative was based on site and was aware of any incident or accident that occurred in the centre. The provider representative received daily updates in relation to any incidence/accidents. For example, she was appraised about any falls, pressures sores, wounds, level of restraint and any significant events occurring. The provider representative in conjunction with the maintenance officer and person in charge managed health and safety issues within the centre. The inspector was informed that this management group met regularly to review all incidents and accidents and the most recent meeting was recorded in August 2017. This meeting also reviewed procedures and practices including risk management and fire safety in the centre. All accidents and incidents were recorded on incident forms, were submitted to the person in charge and provider representative. The inspector noted that there was evidence of suitable actions in response to individual incidents. For example, from a sample of records of incidents involving residents it was clearly recorded the action taken to support the resident following any untoward event. There was recorded information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning/changes required to prevent reoccurrence. The health and safety statement seen by the inspector was center-specific and had been reviewed most recently in February 2017. There was a risk management policy as set out in schedule 5 of the regulations. This policy covered the identification and assessment of risks and the precautions in place to control the risks identified. Clinical risk assessments were also undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. The risk management policy contained the specific measures and actions to control the specific risks as required by regulation 26(1). However, some of these risk assessments were not adequate as some sections had been left blank for example in relation to the risk assessment result. In addition, the design/format of some of the risk assessments records were not adequate. For example, a number of the risk assessment forms were prepopulated with the risk quantification at "high" prior to implementation of hazard controls. Then each risk assessment form had a prepopulated the subsequent risk quantification as "low" after hazard controls for each risk identified. This prepopulating of the risk assessments records could not accurately reflect all risk assessments in advance of controls being implemented and was therefore not always an accurate reflection of the actual assessed risks.

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the centre. The fire policies and procedures were centre-specific. There was a designated smoking area near the main entrance and there was a no smoking policy implemented for the remainder of the premises. The person in charge confirmed that three residents smoked in the centre. The inspector noted that

two of these residents had smoking risk assessments and care plans in place. However, one resident who smoked tobacco occasionally and only then under supervision; did not have any care plan or smoking risk assessment in place.

The fire safety plan was viewed by the inspector and found to meet HIQA regulatory requirements. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. Staff demonstrated appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was most recently provided in January 2017. Fire training was also provided on the evening of the first day of the inspection. This training had been scheduled and all staff had up to date fire training, as required by legislation. The person in charge told the inspector and records confirmed that fire drills were undertaken at a minimum each quarter in the centre and were conducted both during day and evening times. The inspector examined the fire safety register which detailed services and fire safety tests carried out. Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. All fire door exits were unobstructed and fire fighting and safety equipment had been tested in January 2017. Records viewed recorded that the fire alarm was tested quarterly and last tested in August 2017 and the emergency lighting was last serviced in February 2017. However, the emergency lighting was not reviewed/maintained quarterly by a competent person.

Each resident had a detailed personal emergency evacuation plan (PEEP's) in place. However, the PEEP records viewed were not adequate as they did not contain details regarding the residents level of supervision when brought to a place of safety following evacuation

The provider representative had contracts in place for the regular servicing of equipment and the inspector viewed these records which were up-to-date. The inspector noted that there was a passenger and chair/stair lift available in the centre and records reviewed evidenced that both lifts had been most recently serviced in April 2017. There were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on most corridors and safe walkways were seen in the outdoor areas.

Overall the premises, including the communal areas and bedrooms were found to be clean and there was adequate standard of general hygiene at the centre. All hand-washing facilities had liquid soap. There were policies in place on infection prevention and control and there was personal protective equipment such as latex gloves and plastic aprons available in designed cupboards. Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. For example, regular training of staff, subtle staff infection control reminder notices and strategically placed hand sanitizer dispensers throughout the premises. Most staff that were interviewed demonstrated adequate knowledge of the correct procedures to be followed. The training matrix indicated that all staff had completed training in hand hygiene and infection prevention and control. On the previous inspection there had been improvements required in relation to the premises for example, the internal courtyard's surface needed to be upgraded, repair of some furniture and there was damaged paintwork. The inspector noted that there was a programme of ongoing upgrading works in the centre and these issues had been completed or near completion

at the time of inspection.

Care plans reviewed contained a current manual handling assessment which had been completed and these plans referenced the specific equipment required for resident and staff safety. Manual handling practices observed were seen to be in line with current best practice. The training matrix recorded that all staff were trained in manual handling. Documentation seen indicated that the hoist required for moving techniques in resident care was serviced regularly and most recently in June 2017.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

On the previous inspection there had been significant failings identified in relation to the management of medication in the centre however, on this inspection the inspector noted that there had been considerable improvements in this area. For example, there had been a review of medication management practices and the medication policy had been reviewed and amended to reflect the current An Bord Altranais agus Cnáimhseachais (Irish Nursing and Midwifery Board of Ireland) guidelines. This policy had been made available to all nursing staff who had signed to confirm that they had read and understood its contents. There had also been monthly audits completed in relation to the adherence of nursing staff to this policy and the audit results were regularly reviewed by the person in charge and the provider representative. The supplying pharmacist had provided medication audits on a monthly basis. All nursing staff had completed medication competency assessments including any new nursing staff who completed this assessment as part of their induction. The inspector was informed that these competency assessments were to be repeated annually and/or following any medication error or incident. All nursing staff had also completed further medication management training including training with the supplying pharmacist that had been provided on-site to both nursing and healthcare staff. From speaking to nursing staff, a review of a sample of medication administration records and residents' care plans; there was evidence of adequate medication reconciliation processes had been established in the center. The inspector noted that all the required information was available to nursing staff within 72 hours of each resident's admission.

Medicines for residents were supplied by a community retail pharmacy. Nursing staff with whom the inspector met outlined an adequate procedure for the ordering and

receipt of medicines in a timely fashion. Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. Staff informed the inspector that there were no residents currently self-medicating in the centre.

Medications requiring additional controls under the Misuse of Drugs Regulations were seen to be suitably stored and robust measures were in place for the handling and storage of controlled drugs and were in accordance with current guidelines and legislation including the Misuse of Drugs Regulations.

Nursing staff with whom the inspector spoke demonstrated adequate knowledge of the general principles and responsibilities of medication management. Medication administration was observed at lunch time on the first day of inspection. The inspector found that the nursing staff adopted a person-centred approach and a sample of medication prescription records was reviewed. Medicines were recorded and administered in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

On the previous inspection improvements were required to ensure each care plan was developed to contain sufficient information to specify the actual problem identified and guide the necessary care interventions of residents to inform an evaluation. On this inspection the inspector noted from a sample of care plans reviewed that each residents' care plan and care needs were contemporaneously recorded and reflected changes in their circumstances and identified health and social care needs. There was a nurse key worker system in place which ensured that nursing staff were clinically accountable for ensuring individually named residents care needs were being met. The person in charge

informed the inspector that she now monitored and reviewed residents care plans on a weekly basis or more often if required. The inspector noted from a review of residents care plans evidence of care plan reviews and all were up to date accordingly.

Overall the inspector was satisfied that residents' healthcare requirements were met to an adequate standard. There was a canter specific admissions' policy that had been most recently reviewed in My 2017. Residents had good access to GP services with evidence of regular GP reviews from the sample of residents' records reviewed. There were assessments of residents overall health and social care needs on admission and on readmission following return from acute hospital care and as required for example, when clinical deterioration was noted. The inspector saw that residents had a comprehensive nursing assessment completed following admission. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. There was evidence of access to specialist and allied healthcare services to meet the care needs of residents. For example, Speech and Language Therapist (SALT), Psychiatry, opticians, dentists and chiropody services. Access to palliative care specialists, dietician and physiotherapy were also available. Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. From a review of care plans, there were details to support staff in effectively managing residents' health problems. The person in charge closely monitored the care planning system to ensure that residents support and care needs were met. For example, the person in charge/staff nurse attended the handover meetings, liaised with GP's and allied healthcare professionals and regularly reviewed care plans to ensure appropriate care provision. The inspector found that the care plans were person centred and individualised. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs.

Care plans were audited in the centre with the most recent audit completed in September 2017. Assessments and care plans were reviewed four-monthly or more frequently as required. A daily nursing record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. Overall there were adequate systems in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. Based on a random sample of care plans reviewed; overall the inspector were satisfied that the care plans reflected the resident's assessed needs, assessment was supported by a number of evidenced-based assessment tools and plans of care to meet most identified needs. However, some improvements were required in the care planning implementation. For example, there was a resident with responsive behavior's who had suitable assessments and care planning records in place which had contemporaneously recorded each incident of responsive behaviour. However, there was insufficient evidence from the care plan of suitable review/response to this emerging clinical information and it was not evident that this information had been effectively used to develop the residents' care plan or inform care practice to address this care need.

The inspector noted that there were a number of residents who required Percutaneous

Endoscopic Gastrostomy Feeding (PEG) and there was adequate care plans in place to guide nursing and healthcare staff practice. Residents when receiving PEG feeds were monitored by nursing staff however, such monitoring of the resident when receiving PEG feed was not adequate as there was no written records maintained of this monitoring. However, the inspector noted that the person in charge immediately implemented a monitoring record of residents when receiving PEG feeds on the afternoon of the first day of inspection.

There was evidence of active falls prevention in the centre. For example, falls were monitored and audited closely, all residents had been risk assessed in relation to their risk from falls. The level of falls in the centre was reviewed regularly by the management group meetings to promote the reduction in the incidence of falls within the center. This management meeting reviewed any incidences of slips, trips or falls in the center. All incidences of falls were reviewed individually to identify any possible antecedents or changes/learning that could be obtained to prevent any re-occurrence. Subsequently, measures were identified in residents' falls prevention care plans and there were also reassessments of falls risks by staff after each fall. The inspector was satisfied that all staff spoken with were familiar with each resident's needs. Overall care plans contained few identified deficits between planned and delivered care. Residents and their representatives to whom the inspector spoke were complementary of the care, compassion and consideration afforded to them by staff.

Judgment:

Substantially Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

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

Findings:

On the previous inspection, improvements in the complaints process had been identified to ensure that there was a nominated person other than the person who manages complaints was in place to ensure that all complaints are appropriately responded to and the required records are maintained. The inspector noted that the person in charge was now this nominated person under Regulation 31(1)(c) and a company director had been appointed as the complaints officer as referred to under Regulation 34(3).

The complaints procedure was displayed near the main entrance to the centre and it described how to make a complaint and reflected the above changes. The complaints procedure was also referenced in the statement of purpose and the residents' guide and

copies of which were made available to residents. The inspector read a sample of complaints records for 2016 and 2017. The details of each complaint were recorded and the inspector saw that there was a prompt response to each complaint. The complaint's policy listed details of the nominated complaints officer within the centre and included an appeals procedure.

Residents spoken with said they would have no hesitation speaking to any of the staff if they had a concern, all spoken to stated that they were happy with the service provided in the centre. However, the recording of complaints was not adequate as most but not all complaint records recorded whether or not the resident was satisfied following making a complaint.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

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

Findings:

On the previous inspection, improvements had been identified in relation to the overall assessment, planning and recording of end-of-life care including the physical, psychological and spiritual needs of the residents, including residents' preferences regarding their preferred setting for delivery of care had not been completed with all residents and or family. However, on this inspection most of the actions from the previous inspection had been completed in relation to end of life care.

At the time of inspection there was one resident receiving end of life care. Overall there was evidence of a good standard of medical and clinical care provided. From the sample of residents care plans reviewed there was an end-of-life assessment record for residents. There was some recorded evidence available to demonstrate that the resident or their representatives were involved where appropriate in end-of-life decisions. Appropriate access to specialist palliative care services was provided. There was a centre specific policy on the management of end of life care available and staff spoken to were knowledgeable and aware of the policies and processes guiding end of life care. Staff to whom the inspector spoke outlined suitable arrangements for meeting residents' needs, including ensuring their comfort and respectful care practices in relation to end of life care provision. However, further improvement was required in relation the recording of residents' spiritual needs and in updating residents' plan for medical intervention at the

end of their life.

The inspector noted that families were notified in a timely manner of deterioration in residents' condition and were supported and updated regularly as required. The inspector was told that wherever possible, a choice of a single room or alternative arrangements for residents in shared bedrooms was made available when residents were approaching their end of life. There were some facilities to support relatives remain with their loved ones during end-of-life and for families to remain overnight, if required. Relatives or friends could be accommodated in the first floor sitting room with refreshments made available. Staff spoken to also outlined how religious and cultural practices, including religious services, were facilitated within the centre.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector noted a homely atmosphere in this small centre that appeared to be due to the overall ethos of the service which upheld the individual rights, dignity and respect for each resident. Residents to whom the inspector spoke confirmed that they were consulted on a daily basis and were always afforded as much choice as possible. A number of residents stated that the centre was "like home from home", that "the staff could not do enough for you". Residents were seen to be well cared for, comfortable and generally appeared relaxed in the centre. Both the person in charge and the provider representative knew all residents well and met and spoke with each of them on a daily basis. The nursing assessment included an evaluation of the resident's social and emotional wellbeing. The daily routine was organised to suit the residents. All staff including catering staff, optimised opportunities to engage with residents and provide positive connective interactions. There appeared to be a positive and friendly atmosphere in the centre particular between residents and staff. There was evidence that activities were chosen in collaboration with residents, and that residents were satisfied with activities that were arranged. The inspector observed that residents were free to join in an activity or to spend quiet time in their room. There were a some organised activities provided and other small group or one to one activities were

facilitated by staff which reflected the capacities and interests of each resident. However, the provider representative outlined how activities were decided by the residents on a daily basis and only following consultation with residents. While some organized/scheduled group activities such as bingo, rosary or armchair exercises were provided however, the provider representative informed the inspector that the emphasis was to facilitate activities that residents were interested in on a daily and small group basis. The inspector observed that this was the case with small group activities or individual one to one activities being provided. Staff were observed connecting and interacting with residents in a positive and supportive manner and created opportunities for one-to-one engagement, for residents who were unable or unwilling to participate in groups.

There were a number of the staff involved in providing recreation and engaging activities for residents. Activities such as music were provided by people from outside the core staff. In addition to activities held in the centre, outings were organised to local events and areas of interest such as a bus trip to the Rock of Cashel. There had been a garden party held in the grounds of the centre in July which according to residents this had been a great day. There had been lots of residents' relatives and friends that had attended this event in the centre which had a "country and western theme", with lots of music and a number of outside performers. Since the success of this event the provider representative informed the inspector that she was planning with residents through the residents committee' to organize another similar event and this time the suggested theme looked like it might be "a 50's show" possibly in November.

There was an active residents' committee in place and the inspector reviewed the minutes of the most recent committee meeting held in September 2017. It was recorded that the committee was actively involved for example, in organizing birthday celebrations for residents and having an outsider music performance in the centre which was planned for this coming November. This committee had previously been involved in producing a residents' cookbook that according to the provider representative had been very popular and in high demand.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

On the previous inspection there had been improvements required in relation to staffing and the arrangements for the person in charge to fulfill her managerial responsibilities. However, since the last inspection the person in charge had been allocated protected time consisting of a nine hour day to carry out management responsibilities and duties. For example, pre-admission assessments, in house audits and staff appraisals to ensure the effective delivery of care. There had been some improvement in the supervision arrangements for nurses and improved accountability. For example, there were nurse care plan allocation system, nurse medication management competency reviews, staff appraisals, staff meetings and a structured staff induction process in place. The inspector spoke to recently recruited nurse who confirmed that they had received induction and suitable training.

In relation to staffing; the provider representative stated that there was no issue with staffing at the moment. The person in charge and staff to whom the inspector spoke also stated that staffing in the centre was adequate. This was confirmed by a review of the staffing roster, reviewing residents' dependency profile, speaking to residents and reviewing care planning documentation, speaking to staff and review of minutes of staff and management meetings.

An actual and planned roster was maintained in the centre. The inspector noted that the person in charge worked full time. She was also available if required on call to staff outside of the normal working hours and while scheduled to be off duty. The inspector noted that the person in charge was scheduled to be off duty however, she attended the center and made her self available on both days of the inspection. The inspector observed practices and conducted interviews with health care assistants, household staff including the Cook, the person in charge, staff nurses and the provider representative.

Residents spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs as well as their likes and dislikes.

There was an education and training programme available to staff. The training matrix indicated that mandatory training was provided and a number of staff had attended training in areas such as manual handling, dementia and safeguarding and safety.

The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector. The provider representative confirmed that all volunteers and all staff in the centre had been suitably Garda vetted.

Judgment: Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Vincent Kearns
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Willowbrook Lodge
Centre ID:	OSV-0000302
Date of inspection:	26/09/2017 and 27/09/2017
Date of response:	17/10/2017

Requirements

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

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

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

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

1. Action Required:

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

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

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

Where we act as an agent in respect of pension payments we will comply with the Department of Social Protection guidelines for pension agents, unless specifically requested, in writing by the relevant resident or their representative to hold any monies on site. In such instances we will comply with the residents /representatives wishes.

Proposed Timescale: 12/10/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

2. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

A quantifiable risk assessment with a risk assessment result as shown to the Inspector at the inspection is now in place.

Proposed Timescale: 02/10/2017

Theme:

Safe care and support

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

To make adequate arrangements for reviewing fire precautions including suitable risk assessments and care plans for residents who smoked tobacco.

3. Action Required:

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

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

Risk assessments and care plans for residents who smoke have been updated.

Proposed Timescale: 12/10/2017

Theme:

Safe care and support

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

To make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents including by ensuring that the PEEP records contain adequate details regarding the residents level of supervision when brought to a place of safety following evacuation.

4. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

A new PEEP record as shown to the Inspector at the inspection is now in use

Proposed Timescale: 02/10/2017

Theme:

Safe care and support

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

To provide adequate means of escape, including emergency lighting including quarterly maintenance by a competent person.

5. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

Emergency lighting maintenance by a competent person will be carried out at the required intervals.

Proposed Timescale: 31/10/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

To arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2) including by ensuring effective care planning implementation for all residents' care needs.

6. Action Required:

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

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

We will utilise evidence from assessments and care plan records to meet the needs of each residents care needs.

Proposed Timescale: 12/10/2017

Outcome 13: Complaints procedures**Theme:**

Person-centred care and support

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

To ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

7. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

Details of resident satisfaction will be recorded on each complaint.

Proposed Timescale: 04/10/2017

Outcome 14: End of Life Care**Theme:**

Person-centred care and support

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

To provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned including adequate records of residents' spiritual needs and in updating residents' plans in relation to medical intervention at the end of their life.

8. Action Required:

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

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

We will provide appropriate care and comfort to a resident approaching end of life particularly in relation to medical intervention.

Proposed Timescale: 30/11/2017