

# eDeposit Ireland

## Woodlands Nursing Home, Bishopswood, Dundrum, Tipperary

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Woodlands Nursing Home
<b>Centre ID:</b>	OSV-0000304
<b>Centre address:</b>	Bishopswood, Dundrum, Tipperary.
<b>Telephone number:</b>	062 71 335
<b>Email address:</b>	paddy@wnh.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Tipperary Healthcare Limited
<b>Provider Nominee:</b>	Paddy Fitzgerald
<b>Lead inspector:</b>	Gemma O'Flynn
<b>Support inspector(s):</b>	Sonia McCague
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	39
<b>Number of vacancies on the date of inspection:</b>	4

## 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 13 December 2016 08:00 To: 13 December 2016 19:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

**Summary of findings from this inspection**

This report sets out the findings of a one day announced inspection, the purpose of which was to inform the renewal of the centre's registration. The inspection also followed up on the 15 action plans associated with the centre's previous inspection in September 2016. Twelve action plans were completed or satisfactorily progressed and three remained outstanding. Two of the outstanding actions related to documentation and one related to staff training.

Following the previous inspection the provider nominee was invited to attend a meeting in HIQA to discuss the centre's non-compliances with the regulations. The provider put forward a plan for addressing non-compliances in the centre. On this inspection, inspectors formed the judgment that the provider had implemented the plan that he had outlined and demonstrated a commitment to ongoing improvements in the quality and safety of care. Significant improvements in previously identified issues relating to staffing, medication and premises had taken place.

As part of the inspection process, inspectors met with residents, staff, the person in charge and the provider nominee. Residents' views were heard, staff spoke with inspectors and described the care they delivered to residents, practices were observed and documentation was reviewed.

Overall, on the day of this inspection, inspectors found that care was delivered in a relaxed environment by staff who knew the residents and their needs well. Residents voiced satisfaction with the way in which the centre was managed and run and gave very positive feedback about the staff. Residents who spoke with inspectors said that they felt safe there.

Inspectors' judgments against the outcomes examined are set out in the table above and discussed throughout the report and associated action plan.

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 01: Statement of Purpose***

***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

The statement of purpose consisted of a statement of the aims, objectives and ethos of the designated centre and a statement as to the facilities and services which were to be provided to residents.

It contained all of the information required by schedule 1 of the regulations and had been reviewed in September 2016. The statement of purpose was implemented in practice.

**Judgment:**

Compliant

***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 day of inspection the centre was adequately resourced to deliver the care as

described in the statement of purpose. Staffing resources had been addressed since the previous inspection in September 2016. Since new nursing staff had been recruited, the person in charge had resumed her supernumerary role and two nurses instead of one were allocated to the day shifts 08:00hrs to 20:00hrs. The person in charge stated that three additional nursing staff were in place since the previous inspection, they had two relief nursing staff and were awaiting registration for three additional nurses.

There was a clearly identified management structure in place. Staff and residents could identify senior management and said that they were approachable if they had any concerns. The provider nominee and person in charge had commenced weekly meetings to formally review the service. An action plan had developed as a result of these meetings and these were updated and amended as required. The provider nominee said that he intended on continuing these regular management meetings.

Audit systems were in place and were under review with a view to developing a comprehensive audit process. For example, falls reviews were carried out three monthly and gathered meaningful data such as the time and location of resident falls in an effort to identify any trends. Since the previous inspection the person in charge had engaged the services of the physiotherapist in the review of resident falls in an effort to develop effective strategies to minimise future recurrences. Medication audits were reviewed and the person in charge had identified areas for improvement, it was evident from documentation that these issues had been followed up with the relevant staff members. The provider nominee and the person in charge both told inspectors that they were in the process of the developing the audit process in line with national standards, so as to aid ongoing improvements in the quality and safety of care.

The annual review for 2016 was available on the day of inspection. This outlined the vision for the centre and reviewed details such as occupancy levels, training undertaken in 2016 and a training plan for 2017, a review of the number of resident falls annually and an action plan for 2017 to reduce same. Also included was an audit review and a summary of complaints received. The provider nominee stated that plans were in place for further decorative upgrade in the centre in 2017 such as the purchasing of new seating and replacing bedroom lights.

Residents had access to a regular forum where they were consulted on the running of the centre. Minutes showed that attendance averaged 16 residents. Agenda items included premises, quality of the food, entertainment and activities and satisfaction with newspaper availability and or selection. Residents confirmed that these meetings took place and that they could contribute their views when they wished.

The provider nominee and person in charge said that they planned to issue a residents' survey in early 2017.

**Judgment:**  
Compliant

***Outcome 03: Information for residents***  
***A guide in respect of the centre is available to residents. Each resident has an***

***agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There was a guide to the centre available to residents and this outlined the services and facilities in the centre. A sample of contracts of care were reviewed and these dealt with the care and welfare of residents in the centre and set out the services to be provided and the fees being charged to residents.

The provider nominee was in the process of renewing contracts for a number of residents due a to change in the fee structure. A number of new contracts had been signed and returned to the centre.

**Judgment:**

Compliant

***Outcome 04: Suitable Person in Charge***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The person in charge of the designated centre worked Monday to Friday from 09:00hrs to 17:00hrs. She was on call outside of those times. She was a qualified nurse with the required experience in nursing the older adult. She demonstrated knowledge of the residents clinical needs and of her statutory responsibilities. She was engaged in the governance of the centre on a regular and consistent basis since her staffing levels had rectified and she was no longer working full time in the capacity of staff nurse.

She had undertaken a management course in 2013 and stated she was planning on undertaking some additional practical training in 2017 such as training in undertaking catheterisation.

**Judgment:**

Compliant

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

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

Improvements were required in documentation practices relating to care practices, policies and staff records.

Records were maintained in the centre and overall, records requested over the course of the inspection were available for review. Some improvement was required to address the recording gaps found in the completion and maintenance of bedrail safety check in the sample of residents records reviewed, in line with Schedule 3(4)(g).

The centre held the policies as required by schedule five of the regulations and these had been reviewed and updated in 2016. Some policies required review to ensure that they fully reflected the practices of the centre such as the policies relating to the use of restraint, end of life that includes resuscitation status and management procedures, the policy on care planning, development and implementation and the management of residents' finances.

A random selection of staff files were reviewed on inspection and not all held the items required under schedule two of the regulations. For example, there were gaps in employment histories for some staff. Copies of relevant qualifications were not on file for all staff. An up to date certificate of registration with the Nursing and Midwifery Board of Ireland (NMBI) was not available for all relevant staff.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Absence of the Person in charge***  
***The Chief Inspector is notified of the proposed absence of the person in***

***charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

**Theme:**

Governance, Leadership and Management

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

**Findings:**

There had been no incidences whereby the person in charge had been absent for periods of 28 days or more. The provider and person in charge were aware of their statutory responsibilities in this regard. Two senior nurses were appointed to deputise for the person in charge if the need arose.

**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.***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Measures were in place to protect residents from being harmed or suffering abuse. There was a current policy which provided guidance for staff on the various types of abuse, assessment, reporting and investigation of incidences. It also included how to report and manage incidents of elder abuse.

The person in charge clearly demonstrated her knowledge of the designated centre's policy and was aware of the necessary referrals to external agencies, if required.

Staff confirmed and training records indicated that staff had attended training on the prevention, detection and response to abuse. Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were in place to ensure the safety of residents.

Measures had been taken to safeguard residents while at the same time afford them opportunities for maintaining independence and fulfilment. For example, staff rooms had a lock or keypad such as cleaning, office and treatment rooms and the entrance or exit doors. All other communal areas were accessible to residents. Inspectors saw that there were facilities in place to assist residents to retain their independence and mobility for example, modified chairs and handrails fitted along corridors and circulating areas. A call-bell facility was available to residents in their rooms.

Residents who spoke with inspectors confirmed that they felt safe in the centre due to the measures taken such as a locked door entrance and staff presence day and night. Relatives were also satisfied that residents were protected from harm and were safe in the designated centre. Residents and relatives were satisfied with staff support and the care provided by the staff team.

A policy encompassing the principles of the national guidance document on restraint was available to define and guide restraint usage. Some improvement was required to ensure the policy was implemented in practice or that practice was reflected in the policy, as outlined in outcome 5.

An aim to promote a restraint free environment in line with the national policy was described. A high rate (49%) in relation to the use of bedrails by 19 residents was reported. This was acknowledged by the management and staff team who were undertaking regular reviews as seen in resident's records and in the restraint register maintained. Risk assessments had been completed and while records of decisions regarding the use of bedrails were available to show some decisions were made in consultation with the resident or representative, staff nurse and General Practitioner (GP), not all decisions included a multidisciplinary input, as outlined in outcome 11. Interventions read in care plans included regular checks of restraint practices. However, recording gaps in the completion and maintenance of safety check was found in the sample of residents records reviewed. This is included in the action plan of outcome 5.

Some residents told an inspector they liked a bed rail to keep them safe and aid movement. Staff spoken with confirmed this and highlighted the various alternatives available and that had been tried prior to the use of bedrails. Equipment such as low-low beds and sensory alarms were available to reduce the use of bedrails. The person in charge told inspectors she was sourcing foam wedges to trial as an alternative to bedrails used by some residents.

A policy was available entitled 'challenging behaviour and the use of psychotropic drugs'. The policy was reflected in practice. Due to medical conditions, some residents had responsive behaviours. A small number of residents were prescribed PRN (as required) psychotropic medicine. The nurse medication administration records reviewed showed a rare use of the PRN medicine prescribed. Residents were provided with support and distraction techniques that promoted a positive approach to changes in behaviours. Support from the resident's doctor and from the community psychiatry team was available. Staff spoken with were familiar with each resident and of the appropriate interventions to use to respond to a change or escalation in residents behaviour. During the inspection staff approached residents with responsive behaviour in a sensitive and appropriate manner and the residents responded positively to the techniques used by

staff.

There were systems in place to safeguard residents' money. Records were up-to-date. The provider stated that the arrangements for holding and documenting residents finances were under review to ensure that they corresponded with the guidance set out by HIQA. There was a policy for the management of residents' fees and other expenses dated August 2016 but this did not set out how petty cash or other monies held for residents were managed. This is actioned under outcome five: documentation.

**Judgment:**  
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):**

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

**Findings:**

The centre had policies and procedures relating to health and safety. An up-to-date health and safety statement dated October 2016 was in place. A risk management policy was also in place as required by the regulations dated July 2016, however, this policy did not refer to all the items set out in the regulations. This was brought to the attention of the person in charge who reviewed and rectified the policy prior to the close of inspection. A risk register was in place and this assessed risks associated with identified hazards and set out the controls required to minimise the associated risk. Risk assessments were completed for residents who smoked and controls were seen to be implemented over the course of the inspection. Since the previous inspection a weekly environmental hazard audit was undertaken to identify any new or changing hazards. Feedback from the staff responsible for this task was that this was a positive proactive interventions and any identified issues generally addressed immediately by the maintenance team.

There was a plan in place for responding to major incidents dated November 2016. This outlined potential emergencies and contact numbers and also identified alternative shelter if an emergency evacuation of residents as required.

Issues identified on previous inspections regarding infection control management had been resolved on this inspection. There were satisfactory procedures in place for the prevention and control of healthcare associated infections. A policy was available dated April 2016 and this was complemented by additional more detailed policies that dealt with specific types of infection outbreaks. Key staff outlined what constituted an infection and infection control practices that were observed were in line with good

practice. Links were in place with external agencies who could provide specialist advice in the area of infection control if so needed. Household staff were able to describe the protocols and procedures in place for effective cleaning of the centre. Audits of hand hygiene, the emergency plan and housekeeping had taken place since the previous inspection and an action plan developed where necessary.

Arrangements were in place for investigating, recording and learning from incidents or adverse events involving residents. Documentation evidenced that where it was determined the input from allied health professionals was required following adverse events such as the services of a speech and language therapist, referrals were made in a timely manner.

Suitable fire fighting equipment was provided and servicing records for equipment, alarms and emergency lighting were up to date. Records were seen for daily inspection of escape routes to ensure that they were unobstructed at all times. All staff on the roster had received fire safety training. Staff who spoke with inspectors demonstrated an awareness of what to do in the event of a fire and confirmed that regular drills took place. Records indicated that all but one member of staff had taken part in at least two drills in 2016. All staff had participated in one drill.

Overall, documentation relating to fire drills was informative and demonstrated learnings and areas that required improvement. The person in charge discussed changes to the fire evacuation protocol as a result of learning from the drill. These included delegating four specific duties to staff at the time of the fire alarm sounding or ensuring the provider nominee and or person in charge were called at night. However, it wasn't evident when discussing fire drills with staff that they were aware of these important learnings. Fire evacuation notices were displayed but hadn't been updated with the new protocols resulting from the completion of fire drills.

**Judgment:**  
Substantially Compliant

***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:**  
Residents were protected by medication management policies and practices seen in the centre.

Written operational policies relating to the ordering, prescribing, storing and

administration of medicines to residents were available to guide staff. The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with relevant guidelines and legislation.

A medication round was observed by an inspector. Nursing staff demonstrated safe practices in the administration and management of medicines.

The actions arising from the previous inspection were addressed. A previous findings relating to the medicine trolley left unattended, stocked and unlocked was addressed. Nurses ensured the trolley was locked when unattended by them during a medicine round observed. The arrangements for the safe storage and return of discontinued medication to the pharmacy were also addressed since the previous inspection.

Systems were described and in place for ordering, supply and dispensing methods. There were appropriate procedures for the handling, checking, return and disposal of medicines.

A pharmacist was available to support medicines management for residents in the centre.

Systems were in place for reviewing prescriptions and monitoring medicines management practices. An arrangement for the review of prescribed medicines by the GP on a three monthly basis was in place and records available demonstrated this arrangement was implemented in practice to enhance safe practices and resident well-being.

**Judgment:**  
Compliant

***Outcome 10: Notification of Incidents***

***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**  
Safe care and support

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

**Findings:**  
A record of all incidents occurring the designated centre was maintained. Notifications that required submission the HIQA had been completed. Quarterly notifications were submitted as required. The provider and person in charge were reminded of their statutory responsibilities regarding six monthly nil-returns.

**Judgment:**  
Compliant

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***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:**  
The healthcare and social care needs of residents were facilitated. While the action arising from the previous inspection relating to the management of wound assessments was addressed and improvements in care plans was noted, further improvements in the care planning and recording process were required.

Arrangements were in place to ensure each resident had access to appropriate nursing, medical and allied health care.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services.

A selection of care records and plans were reviewed. There was evidence of a pre-assessment undertaken prior to admission for residents. Following admission there was an assessment of activities of daily living, including communication, personal hygiene, elimination, eating and drinking, mobility, spirituality and sleep. There was evidence of a range of assessment tools being used to monitor the risk of falls, malnutrition and pressure ulcer development. Dependency assessments to determine functional capacity were also calculated using a recognised assessment tool.

The development and review of care plans was completed by nursing staff. The statement of purpose included that residents or their representatives were formally invited to review care plans. While care plans were subject to regular reviews, there was little recorded evidence to demonstrate involvement by residents and or relatives in the care plan review process.

Care plans required review to ensure they guided staff and included agreed interventions and advanced care decisions. For example, a care plan for a resident with diabetes required review to ensure that details were specific to the individual regarding

the frequency of monitoring and responses required.

A care plan to include details and information known by staff regarding preferred religious, spiritual and cultural practices or named persons to assist residents in decisions to be made at the end of life were noted in the sample of care plans reviewed. However, there was a lack of recorded evidence to demonstrate the plan of care was based on a multidisciplinary assessment to include medical input. Recording arrangements and decisions regarding resuscitation status and management were not maintained in accordance with the policy to include all relevant member of the multidisciplinary team attending to each resident's needs.

While each resident's care plan was subject to a formal review no less frequently than at four-monthly intervals, changes that occurred and specific interventions currently in use were not updated or outlined in some of the care plans reviewed such as wound care dressings, nutritional care and catheter care. While care plans were in place for identified needs, some required improvement to ensure the specifics such as the nutritional arrangements and PEG regime to include the named feed, volume, commencement time, duration and requirement to flush the system at specific intervals was clear. Additionally, the size and type of catheterisation tube, the date of insertion and date to be replaced or changed was not specified to plan or guide appropriate and recommended care.

Weight management is discussed under outcome 15.

Residents told inspectors that they were satisfied with the service provided. Residents had access to GP services and out-of-hours medical cover was provided. Allied healthcare services were available and provided very valuable services to the residents and staff supporting residents. A range of services was available on a referral basis that included speech and language therapy (SALT), dietician, tissue viability, physiotherapy and occupational therapy (OT). Chiropody, dental and optical services were also provided on a referral basis. Records reviewed showed that some residents had been referred to these services and results of appointments were written up in the residents' notes and care plans.

A staff member dedicated to activities co-ordinated a weekly activity programme. Residents were seen enjoying various activities during the inspection. Resident's likes and preferences were known by staff to inform the social and recreational plan and daily activity programme.

Inspectors saw that residents were encouraged to participate in group activities and many of the activities such as the exercises, music, singing and quiz games were particularly suitable or tailored for the resident group. Overall, residents had opportunities to participate in activities that were meaningful and purposeful to them which suited their needs, interests and capacities.

Mobility, repositioning and daily exercises were encouraged. Exercises were included on the weekly activity programme. Residents had suitable mobility aids and modified chairs following seating assessments by an occupational therapist and or the physiotherapist. Hand rails on corridors and assistive grab rails were seen in toilet and bathroom facilities

used by residents to aid their independence.

**Judgment:**

Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**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:**

The design and layout of the centre were in line with the statement of purpose. On the day of inspection the premises met the needs of all the residents there and the design and layout promoted dignity, independence and wellbeing.

Since the previous inspection, the provider had arranged for the completion of significant painting works in the centre. The majority of bedrooms, circulation corridors and the dayroom had all been freshly painted. Beds with rusty bedframes that had been identified as an issue on the previous inspection had been replaced. On the day of inspection, the centre was well lit and warm.

The centre was decorated in a homely manner and there was sufficient furniture and fittings. Residents were seen to relax by a stove or stretched out on a sofa if they so desired. The centre was decorated for Christmas. A large crib was placed in the reception area and a number of Christmas trees were decorated throughout the centre. Residents' artwork was also displayed throughout as were photographs of residents participating in different activities.

On the day of inspection, the centre was clean and free from odour.

Since the previous inspection new personalised name cards had been placed on bedroom doors to assist residents in identifying their own bedroom. These name cards were accompanied by photographs or pictures that were meaningful to each resident, for example, something that referenced a hobby they had a specific interest in.

The layout of the centre supported freedom of movement for residents to use common areas and their personal spaces. There was adequate private and communal

accommodation with two sitting rooms and two dining areas. Bedrooms had the furniture required under schedule six of the regulations, this was an action in the previous inspection report. Some of the bedrooms were smaller than others and the person in charge stated that any prospective resident would be assessed in regards to the accommodation that could be offered to ensure that it met all prospective and current residents' needs.

As identified in the previous inspection report, privacy screening required review to ensure that shared areas of the bedroom were accessible to each resident at all times once the screening was closed. The provider had committed to rectifying this by March 2017 and confirmed that a supplier had been sourced to make the required changes. Some damaged flooring in circulation corridors was also scheduled to be replaced by March 2017.

Residents were supported to individualise their bedrooms and personal bedding and photographs were seen to adorn some residents' bedroom areas. Residents who spoke with inspectors confirmed that they had adequate storage in their bedrooms for personal belongings. Residents had access to a safe external space. Toilets were accessible from the bedrooms and communal areas.

Equipment to support residents was available and safely stored.

**Judgment:**  
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):**

No actions were required from the previous inspection.

**Findings:**

There was a complaints policy for the management of complaints received in the centre dated April 2016. A summary of the complaints process was displayed in a prominent location in the reception area of the centre. The complaints procedure was also outlined in the residents' guide.

The person in charge was the person nominated to deal with complaints. However, there was no person nominated to oversee that all complaints were appropriately responded to and records kept. The person in charge rectified this before the close of the inspection and amended the policy to reflect same.

There were two complaints documented for 2016. The person in charge acknowledged that not all complaints that were resolved locally were documented which was not in line with the centre's policy.

The most recent complaint required review as documentation did not reflect the investigation that the person in charge said she carried out. A brief update had been documented three weeks after the complaint had been received. However, inspectors formed the judgment that there was insufficient evidence recorded to determine that the complaint had been fully and appropriately investigated and any required action fully implemented. The person in charge was asked to review her investigation.

**Judgment:**  
Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

A policy and operational procedures for end of life were in place and available to guide staff and inform care practices. Improvements in assessments, care plans and reviews to include those related to end of life decisions required improvement, as reported under outcome 11.

At the time of inspection inspectors were informed there were no residents at end of life.

Involvement of a multidisciplinary approach to treatment and care that included a palliative care team was described as available. Medical decisions regarding care and treatment decisions at the end of life were to be recorded in the medical notes in accordance with the centre's policy. This required improvement as outlined in outcome 11. There was recorded evidence that some residents' wishes and or their relatives' wishes were discussed during end of life assessment and included in the care plan process.

Staff who spoke with inspectors explained and described how residents and their family had choices and were offered the facilities available and supported with refreshments as required. Most residents had a private single room and alternative arrangements may be facilitated when required by those in twin rooms.

An oratory or mortuary facility was available at the front of the centre with suitable equipment and necessary religious artefacts available to improve the level of respect shown to the deceased and their family.

**Judgment:**  
Compliant

***Outcome 15: Food and Nutrition***  
***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

**Theme:**  
Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Mealtimes observed were unhurried social occasions that provided opportunities for residents to interact with each other and staff. Staff were seen assisting and supporting residents appropriately, in a discreet and respectful manner. As observed on the previous inspection, a number of residents took their meals on bedside tables in the sitting areas of the centre. Staff and residents who spoke with inspectors said this was the residents' preference.

Staff preparing, serving and assisting with meals and drinks were familiar with residents dietary requirements, needs and preference. Staff offered choices and sought resident satisfaction levels during meals requested and provided.

Systems were in place to ascertain residents' views and preferences from a varied menu available on a daily basis.

There were policies in place to guide practice and clinical assessment in relation to monitoring and recording of weights, nutritional intake and risk of malnutrition. Staff were knowledgeable and described practices and communication systems in place to monitor residents that included regular weight monitoring, recommended food and fluid consistency and arrangements for intake recording. Communication systems were in place to ensure that residents nutritional and care needs were available to and known by staff supporting residents to eat and drink and to those preparing and serving food. A list of residents and their specific dietary needs was maintained in the kitchen and the chef demonstrated a very good knowledge of these needs.

Systems were in place to ascertain each resident food preferences on admission and to facilitate residents to provide feedback on the menu options and choices, to inform improvements.

Access to dietician and speech and language therapists was available and provided on a referral basis based on an assessment of need or change in resident condition. Residents were provided with food and drink at times and in quantities adequate for their needs. The food was properly served and presented in an appetising way.

Menus showed a variety of choices at mealtimes and there was a menu on each table.

There was sufficient staff on duty and available to offer assistance to residents in a discreet and sensitive manner. There was an emphasis on residents' maintaining their own independence and appropriate support was provided to promote this. Residents confirmed their satisfaction with mealtimes and food provided. Relatives were positive in their comments about the mealtimes.

Snacks and beverage, including home baking, were offered, advertised and available to residents at intervals between main meals. A variety of drinks were available to residents throughout the inspection.

**Judgment:**

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:**

There was evidence that residents were consulted with and had opportunities to participate in the organisation of the centre in that a resident's committee was facilitated on a regular basis. Residents confirmed this and stated that resident meetings were held regularly, minutes further evidenced this.

Residents' family members and their involvement were central to care and services provided. Staff told inspectors that residents were consulted on a day-to-day basis regarding routines and activities in the centre.

Access to and information in relation to the complaints process and independent advocacy services was available to residents. Residents' independence and autonomy

was promoted. For example, inspectors saw residents being able to access all parts of the centre independently or with support at a time of their choosing, for meals or a group activity.

Practices observed demonstrated residents were offered choices and had written and visual menu options at mealtimes. Residents who spoke with inspectors said they were able to make choices about how they spent their day, when and where they ate meals, rise from and return to bed. Residents had options to meet visitors in a private or communal areas based on their assessed needs.

From speaking with residents and staff inspectors noted that opportunities to maintain personal relationships with family and friends in the wider community was encouraged. Arrangements were provided for residents to attend family occasions and opportunities to socialise and link with the wider community was provided for residents.

Social activities included day centre activities and holiday opportunities for some residents. Overall, the arrangements in place promoted social inclusion, engagement and access to external facilities.

Photographs on display, staff and residents confirmed opportunities to party, socialise with friends and family and events highlighted in the activity programme. Residents were complimentary about a recent Christmas party that included festive drinks and food, a country and western musician and a children's choir as entertainment.

There was a policy on residents' access to visitors and on communications. Visitors were unrestricted except in circumstances such as an outbreak of infection. Radio, television and a cordless phone was available to residents if they wished to use it. Notices were displayed stating that a web based phone video chat system (Skype) was available. Inspectors saw that residents' privacy and dignity was respected and personal care was provided in their own en-suite and bedrooms and they could receive visitors in private.

Staff interactions with residents were in the main seen to be respectful and dignified throughout the course of the inspection. Conversations were meaningful and demonstrated that staff knew the residents well. Residents appeared to be relaxed in the company of the staff they interacted with and confirmed this to be the case when they spoke with the inspector. However, an inspector observed a practice whereby a resident's privacy and dignity was compromised by staff. An inspector observed two staff assist a male resident into the female toilets which were occupied by a female resident receiving staff support. The rationale given was it was located closer than the male toilet facilities. This was discussed with the relevant staff and a suitable arrangement to support residents whilst maintaining their dignity and privacy was developed.

While most staff were seen knocking on resident's bedroom doors and announcing their entry, an inspector observed a staff member walk directly into a resident's bedroom without knocking and or announcing herself. The person in charge agreed to communicate the finding with all staff to ensure residents rights, privacy and dignity was promoted at all times.

Residents were seen to be dressed in an appropriate manner with clothes and personal effects of their choosing.

**Judgment:**  
Substantially Compliant

***Outcome 17: Residents' clothing and personal property and possessions***  
***Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

**Theme:**  
Person-centred care and support

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

**Findings:**  
There was adequate space provided for the current residents' personal possessions and mobility aids. Residents who spoke with inspectors confirmed this. Residents' property was recorded on admission and they had a lockable facility in their bedrooms.

There were arrangements in place for regular laundering of linen and clothing, and the return of clothes to residents.

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

**Findings:**

On the day of inspection there was sufficient staff on duty to meet the assessed needs of the residents. Residents who spoke with inspectors confirmed their satisfaction with current staffing levels and said that they were never waiting long for a staff member to come if called. Call bells were observed to be answered in a timely manner over the course of the inspection.

The person in charge confirmed that five days a week there were two nursing staff rostered 08:00hrs to 20:00hrs. On the remaining two days, there were two nurses rostered 08:00hrs to 14:00hrs. The person in charge said that once the newly recruited nurses registration came through there would be two nurses on duty on each 12 hour day shift. In the interim, the person in charge said that she was in the centre until 17:00hrs Monday to Friday and on call at all other times. She stated that if on any given day there were pressures on nursing staff due to circumstances such as resident illness that she would be available to support nursing staff. Nursing staff who discussed this with inspectors said that this arrangement worked well and that there was no risk to residents on the days that additional nursing cover was not provided from 14:00hrs to 20:00hrs.

An education and training programme was in place and was under review. Mandatory training completed for all regularly rostered staff. However, two relief staff were not fully up to date with fire safety training or safeguarding of vulnerable adults. Staff confirmed that these staff hadn't been rostered on duty for some time and the person in charge stated that the required training would be scheduled. Staff were seen to have had training fire safety, safeguarding, safe moving and handling practices, infection control and medication management.

The person in charge stated that all nursing staff were due to complete their updated cardio-pulmonary resuscitation training two days after the close of the inspection.

The person in charge had undertaken to ensure all nursing staff would receive up to date wound management training following the centre's previous inspection. However, this remained outstanding. The person in charge confirmed that 16 residents had a confirmed diagnosis of dementia which was approximately 50 per cent of the residents in the centre. The majority of staff had not received specific training in care of residents with dementia. This was discussed with the person in charge who said that she planned to focus training on care of those with dementia in 2017.

Minutes of staff meetings were available for review and agenda items included matters such as audits, care plans, review of restraint practices and wound care.

Appraisals were seen to be completed in the sample of staff files reviewed. This was an action following the previous inspection. Appraisals determined the staff member's satisfaction with their job and discussed aspects of their knowledge base that they would like to enhance. The person in charge said that she often called to the centre out of hours to supervise care. There was no documented record of these visits or what they entailed.

In the sample of staff files reviewed, a current vetting disclosure was in place. The provider provided verbal assurances to inspectors that all staff had a current vetting disclosure on file. Three members of nursing staff did not have an up-to-date registration certificate on file (this is actioned under outcome five: documentation).

There was one volunteer in the centre and a written service agreement was in place. A vetting disclosure was also on file.

**Judgment:**  
Substantially 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:***

Gemma O'Flynn  
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 report<sup>1</sup>

<b>Centre name:</b>	Woodlands Nursing Home
<b>Centre ID:</b>	OSV-0000304
<b>Date of inspection:</b>	13/12/2016
<b>Date of response:</b>	19/12/2016

### Requirements

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

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

### Outcome 05: Documentation to be kept at a designated centre

**Theme:**  
Governance, Leadership and Management

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

Some policies required review to ensure that they fully reflected the practices of the centre such as the policies relating to the use of restraint, end of life that includes resuscitation status and management procedures, and the policy on care planning, development and implementation.

**1. Action Required:**

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

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

We have revised our system of policy reviews to ensure that all policies are in line with regulation and all external references are consistent with policy and practice.

**Proposed Timescale:** 31/12/2016

**Theme:**

Governance, Leadership and Management

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

The sample of staff files reviewed were incomplete as they did not hold all of the items required under schedule two of the regulations.

Some improvement was required to address the recording gaps found in the completion and maintenance of bedrail safety check in the sample of residents records reviewed, in line with Schedule 3(4)(g).

**2. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All missing documentation is now in place and we shall continue to monitor Staff files to ensure compliance with regulation.

We noted the recording gaps identified by the inspector and have amended hard copy recording sheets to ensure compliance

**Proposed Timescale:** 19/12/2016

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

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

Whilst the procedures to follow in the event of a fire were displayed throughout the centre, they required updating to reflect changes to the protocol as described by the person in charge.

**3. Action Required:**

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

We have amended our protocols to be followed in the event of a fire taking consideration whether day or night, and same have been displayed to enhance our fire response procedures

**Proposed Timescale:** 20/12/2016

### Outcome 11: Health and Social Care Needs

**Theme:**

Effective care and support

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

There was a lack of recorded evidence to demonstrate each plan of care was based on a multidisciplinary assessment. For example medical input and decisions regarding resuscitation status.

While each resident's care plan was subject to a formal review no less frequently than at four-monthly intervals, changes that occurred and specific interventions currently in use were not updated or outlined in some of the care plans reviewed.

Some care plans required improvement to ensure the specifics such as the monitoring, nutritional arrangements and PEG regime to include the named feed, volume, commencement time, duration and requirement to flush the system at specific intervals was included in the current care plan. Additionally, necessary specifics regarding catheterisation such as the size and type of catheter tube, the date of insertion and date to be replaced or changed was not specified to plan and guide appropriate and recommended care.

**4. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

We continue to monitor our care plans to ensure they meet best practice. We have amended the deficiencies noted by the inspector. We have spoken to all nursing staff regarding the importance of timely interventions to all care plans.

**Proposed Timescale:** 31/12/2016

**Theme:**

Effective care and support

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

While care plans were subject to regular reviews, there was little recorded evidence to demonstrate involvement by residents and or relatives in the care plan review process.

**5. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

We are changing our procedures to commence 4 monthly review of careplans in conjunction with residents/relatives. As suggested by the inspector, we shall record same.

**Proposed Timescale:** 31/12/2016

**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:**

There was insufficient evidence recorded to determine that the complaint had been fully and appropriately investigated and any required action fully implemented.

The centre's complaint policy was not fully implemented as all complaints were not recorded as confirmed by the person in charge.

**6. 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:**

We have undertaken a thorough investigation of the aforementioned complaint. We shall endeavour to review our complaints process in line with our policy and have spoken to staff regarding the importance of reporting and recording complaints

**Proposed Timescale:** 16/12/2016

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

The practice of staff assisting a male resident into the female toilets while occupied by a female resident compromised resident privacy and dignity.

A staff member was seen walking directly into a resident's bedroom without knocking and or announcing herself.

**7. Action Required:**

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

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

We continuously strive to protect our residents privacy and dignity and recognise that the aforementioned incident was wrong and should not be tolerated. We have spoken to all staff regarding this unacceptable practice and will monitor compliance with same. The staff member who walked into a room without knocking has also been reminded that residents privacy and dignity is to be maintained at all times

**Proposed Timescale:** 16/12/2016

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

Two relief staff were not fully up to date with fire safety training or safeguarding of vulnerable adults.

Wound management training for nurses had not been completed.

Staff did not have access to specific training in dementia care.

**8. Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

We have booked in the relief staff for fire safety and Safeguarding of vulnerable adults training and have asked them to complete as soon as possible.

All staff nurses who have not completed wound care training, will complete same as soon as possible.

All staff will complete Dementia care training in early 2017

**Proposed Timescale:** 30/06/2017

