Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Older People.

# Issued by the Chief Inspector

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| Name of designated centre: | Willow Brooke Care Centre |
| Name of provider: | Thistlemill Limited |
| Address of centre: | College Road, Castleisland, Kerry |
| Type of inspection: | Unannounced |
| Date of inspection: | 26 July 2023 |
| Centre ID: | OSV-0007842 |
| Fieldwork ID: | MON-0040908 |

## About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Willow Brooke Care Centre is a purpose built facility located in the market town of Castleisland. It is set on 3 acres of landscaped gardens with 2 enclosed courtyards. It is registered for 73 beds. The bedroom accommodation comprises of 55 single rooms and 9 double rooms, all are en-suite with a shower, toilet, wash hand basin and vanity unit. There are several communal areas within the care centre including 5 sittings rooms/ day rooms and an open plan reception area. Willow Brooke Care Centre provides 24 hour nursing care to both male and female residents aged 18 years or over requiring long-term or short-term care for post-operative, convalescent, acquired brain injury, rehabilitation, dementia/intellectual disability/psychiatry and respite.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 60 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

**1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

**2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Wednesday 26 July 2023 | 09:35hrs to 17:40hrs | Ella Ferriter | Lead |
| Thursday 27 July 2023 | 07:45hrs to 17:30hrs | Ella Ferriter | Lead |

## What residents told us and what inspectors observed

This inspection was conducted over two days by an inspector of social services and was unannounced. On arrival on day one, the inspector was greeted by a receptionist and completed the signing-in process. After an opening meeting with the person in charge, the inspector was guided on a tour of the building. The inspector walked through the centre and spent time observing the care provided to residents, talking to residents and staff, and observing the care environment. The inspector met with a large number of residents during the two day inspection and spoke in more detail with twelve residents, to gain an insight into their experience of living in the centre. The majority of feedback from residents was positive and they told the inspector that overall Willow Brook Care Centre was a nice place to live and they were happy. One resident complemented the kindness of the staff and stated "they would do anything for you here" while another told the inspector that they enjoyed the interaction, conversations and fun they had with staff. However, one resident told the inspector that new staff needed more direction and supervision and another told the inspector that staff did not attend to their personal care needs in a timely manner and there were sometimes delays in their care. Overall, the inspector observed that staff engaged positively and interacted respectfully with residents throughout the two day inspection. Residents who were unable to speak with the inspector were observed to be content and comfortable in their surroundings. However, the inspector observed one resident not receiving appropriate supervision in their bedroom, as indicated as required in their care plan for their safety, which is actioned under regulation 7.

Willow Brooke Care Centre is a designated centre for older people, registered to accommodate 73 residents and is situated in the town of Castleisland, County Kerry. There were 60 residents living in the centre on the day of this inspection. The centre is a two story facility situated on a large green site, with views of mountains visible from many of its windows. Bedroom accommodation consists of 55 single bedrooms and nine twin bedrooms, all with en-suite facilities. The centres bedroom accommodation is divided into six distinct wings, all named after types of trees.

Oak, Holly and Sycamore wings are situated on the ground floor and comprise of 24 single and three twin bedrooms. The inspector saw that there was a homely sitting room with a fire place, flat screen television and comfortable seating, on the Sycamore wing (18 beds). Residents also had access to an enclosed paved courtyard. However, the inspector observed on day one, during the walk around, that residents in the Sycamore wing could not independently mobilise into the main communal area of the centre, as the door was locked. The inspector observed that there was signage up and a door bell, with instructions to ring, if you would like to exit the wing. The inspector discussed this with the person in charge on the morning of day one and subsequently the doors were unlocked and remained open for the remainder of the two day inspection. However, a review of restrictive practices and what constitutes a restraint was required, as detailed under regulation 7.

Overall, the inspector observed that the premises was very clean and well maintained, with few exceptions such as walls and door frames which required painting, as detailed under regulation 17. Housekeeping staff were knowledgeable and maintained appropriate records of what was cleaned, including a deep cleaning programme and there were on average three staff allocated to domestic duties per day. However, there was not an adequate system in place for the disposal of contaminated water after cleaning, which is actioned under regulation 27.

The inspector observed that decor in the communal areas throughout the centre was homely and comfortable, however, corridors on the units lacked decor as walls were not decorated and they appeared clinical in nature. The design and layout of the centre, on the ground floor, comprises of a large open plan sitting room/dining room, which was the main focal point of the centre. Over the course of the inspection a number of residents, from both floors of the centre, were observed spending a significant part of the day here. These residents told the inspector that they like to watch the comings and goings of staff and other residents throughout the day, while chatting with each other. The inspector saw on both mornings residents having their breakfast at a time of their choosing and some were seen reading newspapers with a cup of tea. Off this large open plan area was an additional sitting area called the Kingdom Day room, a prayer room, the nurses station, the nurse managers office, an assisted bathroom and the kitchen. There was also a secure outdoor courtyard, with garden furniture, which was in use on day two of this inspection, when the weather permitted. The inspector saw residents sitting outside and being served ice cream cones on day two.

In total the centre could accommodate 43 residents on the first floor. Bedroom accommodation on this floor comprises of the Ash, Elm and Chestnut wings, with six twin and 29 single bedrooms. Bedrooms in the centre were observed to have sufficient space for storage of residents clothes and personal belongings including a double wardrobe, chest of drawers and a locker. Some residents were seen to independently use the lift, while others were assisted by staff. The inspector saw that a few of the twin bedrooms were occupied by couples and they told the inspector that they were happy with their accommodation. Some bedrooms on this floor had balconies off their bedrooms, situated to the front of the building. Communal space for residents on the first floor included a day room called Stacks View, a small dining room, which could accommodate a maximum of ten residents and the Castle View and the Brandon View room. However, the inspector observed on day one of this inspection that the Castle View room had been reallocated to staff and there had been four desks installed in this room. This was discussed on the day of inspection with the management team. Furniture was subsequently removed from this room on the afternoon of day two of this inspection, and the room was reallocated for residents use, as per the centres registration. This is actioned under regulation 9, residents rights.

The inspector also noted on the walk around of the centre that planned changes to the function of two rooms in the centre, in which the provider had applied to change, were not completed. This was particularly in relation to staff changing facilities upstairs and the relocation of the existing laundry, to add additional staff changing facilities, on the ground floor. The inspector was informed that this work

would be completed in the coming months. This is actioned under regulation 17, premises.

The inspector saw that there was a designated external smoking room available for residents to use and there were suitable facilities and protective equipment, to ensure residents safety while smoking, such as a call bell and smoking aprons. The inspector saw residents request cigarettes from staff over the two days and they were assisted to the smoking area. However, from discussions with residents and staff and a review of documentation the inspector was not assured that residents could exercise choice with regards to when they would like to smoke, and had this prescribed in by staff, which is actioned under regulation 7.

All residents spoken with were complimentary about the food and of the choices available on the menu. Fresh scones were available daily and residents told the inspector they could ask for specific foods and they would always be provided. The residents dining experience was observed to be a social experience for residents, and improvements were noted on the first floor, since the previous inspection. The dining tables were appropriately laid out with condiments, cutlery and drinks and menus placed on the tables. Staff were attentive to resident's requests for assistance, and were observed to engage with residents, adding to the social experience. There were dining room assistants employed to supervise meal times and it was evident that they knew residents likes, dislikes and personal preferences. Staff were also observed attending to residents in their bedrooms, to provide support during mealtimes, if required.

Residents confirmed that they had choice over their daily routine, including when to get up in the morning, the clothes to wear and whether or not they wished to partake in the activities scheduled each day. The inspector saw that there were activities provided to residents throughout the two days. There was a lively music session with a guitarist on day two which was attended approximately 30 residents. Residents who were present at the activity said they really enjoyed it. Residents were also observed carrying out chair based exercises with the physiotherapist as well as one-to-one sessions and ball games. The inspector saw that local newspapers were available to residents and residents were reading and chatting about the latest analysis of the All Ireland Football final, which was taking place in a few days. The centre was being decorated both internally and externally with Kerry flags, and residents told the inspector they were looking forward to the match on Sunday. Bingo took place weekly and two residents told the inspector they loved this activity and looked forward to it. A review of residents monthly meeting evidenced that residents had suggested more days out of the centre, and there were plans being put in place for this.

The inspector had the opportunity to meet with four visitors over the two days. They all spoke positively about the centre and told the inspector that staff always made them feel welcome and communicated very well with them about their family members care. They confirmed that there were no restrictions on visiting.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how

these arrangements impacted on the quality and safety of the service being delivered.

## Capacity and capability

Findings of this inspection were that significant action was required by the registered provider to improve the governance and oversight of the service. There were ineffective management systems in place to identify and monitor residents care and welfare, which posed a risk to residents. Action was also required pertaining to contracts of care, protection, training and staff development, the use of restraint and residents rights, to achieve regulatory compliance. These will be detailed under the relevant regulations.

Willow Brooke Care Centre is a designated centre for older persons owned and operated by Thistlemill Limited, who is the registered provider. The company comprises of two directors, who are both involved in the operation of other designated centres in the country. One of these directors is the named provider representative and there was evidence that they were actively engaged in the day to day operation of the centre. The provider employed a director of quality and safety and they were a named person participating in management, on the centres registration. The registered provider had submitted an application to renew the registration of this centre to the Chief Inspector, since the previous inspection, and this inspection would inform part of the decision making process.

There was a clearly defined management structure, with lines of accountability identified. There had been a change in the person in charge in the centre, three weeks prior to this inspection. They work full-time in the centre and had the required experience and qualifications to met the regulatory requirements. They are supported in their role by two assistant director of nursing, two clinical nurse managers and a team of nurses, healthcare assistants, domestic, catering and activities staff. Although there was a clear management structure in place in the centre, some of the findings of this inspection indicated that the governance and oversight of the service was inadequate to ensure a safe service was delivered. The centre also had the support of a human resource and finance department. Records evidenced monthly meetings with the provider, quality manager and the internal management team and regular visits to the centre. The person in charge reported to the provider representative and informed the inspector they were available to the centre on a daily basis.

Overall, the inspector found that there were adequate resources in the centre on the day of inspection, in terms of the staffing levels. However, there was an over reliance of agency staff to support the roster. There was evidence of advanced planning in relation to the staff roster, as the centre required the use of agency nurses on a weekly basis and the human resource department were involved in the planning of staffing resources. However, the inspector found that more robust

procedures were required to ensure that staff not directly employed by the provider were monitored. A sample of five staff files were reviewed by inspector. However, not all staff files were complaint with Schedule two of the regulations,as detailed under regulation 24.

Staff were supported and facilitated to attend training both in person and via on line training methods. There was a comprehensive training matrix maintained electronically. Although there was a high level of attendance at mandatory training for existing staff, the inspector found that for newly recruited staff training was not provided in a timely manner, to ensure that they were competent in care delivery, which is actioned under regulation 16. This inspection also found that there was a sufficient gap in knowledge for nurses in the individual assessment and care planning process, which required to be addressed.

The provider had systems in place to ensure all staff had completed an induction programme, when commencing their role and a nine month probationary period. However, the inspector was not assured that management in the centre were appropriately supervising staff, which impacted and compromised residents healthcare. This is actioned under regulation 16 and supported by the evidence outlined under regulation 6.

Regular weekly data was collected on aspects of care such as incidents, complaints, wounds and falls and there was a schedule of weekly and monthly audits to be completed by the clinical management team. However, a review of audit documents found that they were not always being completed and the system was not being effectively used to identify risks and deficits in the service, which is actioned under regulation 23. Overall, this inspection found that the management systems were in place to monitor the quality and safety of the service were not effective in ensuring that residents care requirements were monitored and to identify areas for improvement.

Incident records were well maintained within the centre and all incidents had been reported to the Chief Inspector, as per regulatory requirements. However, there was not always evidence of learning from incidents such as medication errors and falls, as evidenced on review of records, which is actioned under regulation 23. Policies and procedures, as required by Schedule 5 of the regulations, had been reviewed by the provider at intervals not exceeding three years and were made available to staff. The directory of residents was appropriately maintained and contained the information required by the regulations.

All residents were issued with a contract for the provision of services. However, the fee’s charged for services not covered by the Nursing Home Support Scheme were not detailed in residents contracts of care. The contracts also did not reflect the actual fee's being charged to residents, which is a regulatory requirement and is actioned under regulation 24. The monitoring and oversight of residents finances, for whom the provider acted as a pension agent for were found not to be robust and the system did not safeguard residents, which is actioned under regulation 8 and 23.

## Registration Regulation 4: Application for registration or renewal of registration

The application for registration renewal was submitted to the Chief Inspector and included all information as set out in Schedule 1 of the registration regulations, within the required time frame. However, this inspection found that planned work to the premises to include relocation of staff and laundry facilities had not been completed and these rooms were detailed on the centres statement of purpose and floor plan, this is actioned under regulation 17.

Judgment: Compliant

## Regulation 14: Persons in charge

The centre was being managed by a full time person in charge who had been appointed to the position three weeks prior to this inspection. They had previously held a nursing management position in the centre and had been working in the centre for two years. They had the necessary experience and qualifications as required by the regulations.

Judgment: Compliant

## Regulation 15: Staffing

From an examination of the staff duty rota and communication with residents and staff it was the found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the 60 residents living in the centre.

Judgment: Compliant

## Regulation 16: Training and staff development

The inspector was not assured that the registered provider had appropriate staff supervision arrangements in place to ensure that care delivery was appropriately monitored and delivered. For example, there was not appropriate oversight of healthcare and care planning to ensure best outcomes for residents as evidenced in regulation 5 and 6.

There was evidence that staff were not appropriately trained to deliver effective and safe care to residents. This was evidenced by;

- nine newly recruited staff did not have training provided in people manual and handling and had never received this training in previous employment. The inspector saw that this training was scheduled for September 2023, however, this would result in these staff members being allocated to moving and handling residents, for a two month period, without the necessary training. This posed a risk of injury to residents. This deficit in training was discussed during the inspection and the provider ensured training was scheduled in the coming days. However, further monitoring of this would be required.

Judgment: Not compliant

## Regulation 19: Directory of residents

The provider maintained a directory of residents which contained all information as per Schedule 3 of the regulations.

Judgment: Compliant

## Regulation 21: Records

A sample of five staff files were reviewed by the inspector. One staff file had a statement of employment as opposed to a reference from the persons most recent employer, which is a regulatory requirement.

The inspector also found that some residents records, which were being used to record their daily care and treatment given, did not have the residents name and treatment plan identified on the record, which would not be in line with professional guidance and could lead to errors.

Judgment: Substantially compliant

## Regulation 23: Governance and management

A number of issues were identified with the governance and management of the centre. The management systems to ensure that the service provided was safe,

appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- the system in place to monitor and protect residents finances was not robust and did not protect residents, which is further detailed under regulation 8.
- the auditing system in place was not effective in identifying deficits and risk in the service as identified on this inspection.
- supervision of staff by management was inadequate and inspector was not assured that residents personal care needs were always met. ?
- the inspector was not assured that the clinical oversight systems in place by management were robust. Oversight of residents' nursing and medical needs required action, as outlined the assessment & care planning & healthcare regulations.
- the inspector was not assured that the registered provider had taken sufficient steps in the recruitment and supervision of agency staff, to ensure residents were safeguarded.
- the incident management system was not robust to ensure timely and effective oversight of incidents and to identify opportunities for learning and improving the service.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

A sample of residents contracts were reviewed and they did not comply with the requirements of the regulations. For example;

- the provider charged residents an additional weekly service charge. However, the contract of care did not clearly indicate the services which were included in this weekly fee, which is a regulatory requirement.
- Residents contracts of care had not been updated to reflect a 25% increase in the service charge, which had been initiated in January 2023.
- fees for additional services did not reflect the services being delivered. For example, a residents requiring occupational therapy could not avail of this service and a resident was not given access to a specialised air mattress and had purchased this independently.

Judgment: Not compliant

## Regulation 3: Statement of purpose

The statement of purpose required updating to reflect the centres staffing compliment as the amount of registered nurses listed (14 full time) was not reflective of the amount employed.

Judgment: Compliant

## Regulation 31: Notification of incidents

Incidents and reports as set out in Schedule 4 of the regulations were notified to the Chief Inspector within the required time frames, as per regulatory requirements.

Judgment: Compliant

## Regulation 4: Written policies and procedures

Policies and procedures as set out in Schedule 5 were in place and available to all staff in the centre. These were reviewed at intervals not exceeding three years, as per regulatory requirements.

Judgment: Compliant

## Quality and safety

Overall, the findings of this inspection were that the impact of the poor governance and management of the service directly impacted on the quality of care provided to residents. In particular, this related to inadequate monitoring of healthcare, a care planning system that did not fully direct residents specific care needs, insufficient monitoring of restraint and issues pertaining to residents rights. The inspector was also not satisfied with the measures in place, to safeguard residents finances. These findings will be detailed further under the relevant regulations.

Residents had access to health and social care professionals such as general practitioners, dietitians, speech and language therapists, physiotherapy and tissue viability services. A review of residents records evidenced regular general practitioner reviews and physiotherapy availability twice per week. However, there was not availability of occupational therapy services, which is actioned under regulation 6. A member of the nursing team was a qualified tissue viability nurse and took responsibility for the management and prevention of pressure ulcers. The inspector noted that there were no residents with pressure ulcers on the day of this inspection. However, from a review of documentation, from discussions with staff

and from observations it was evident that a high standard of evidence based nursing care, in accordance with professional guidelines was not consistently provided to residents, which is further detailed under regulation 6; healthcare.

Significant action was required in the individual assessment and care planning process. The inspector reviewed a sample of assessments and care plans and found that while each resident had a care plan in place, this care plan was not always updated as the needs of the resident changed and informed by an assessment of the resident's care needs. This is actioned under regulation 5. Residents receiving end of life care in the centre had their religious and cultural needs met. Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Medication administration charts and controlled drugs records were maintained in line with professional guidelines.

The inspector found that the use of restraint was not in line with national policy. For example there was a high use of bedrails in the centre and sensor mats were not being monitored. Access for residents to communal space was also found to be restricted. From discussion with staff some did not have an appropriate awareness of national guidelines with regard to promoting a restraint free environment and what constitutes a restrictive practice. This will be further detailed under regulation 7.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of their safeguarding training, and detailed their responsibility in recognising and responding to allegations of abuse. Any safeguarding issues identified were reported, investigated and appropriate action taken to protect the resident. The provider had initiated enhanced training for staff in this area over the past year. However, this inspection found that residents, who the provider was a pension agent for did not have their money safeguarded and the systems in place were not robust. This is further detailed under regulation 7, protection.

Residents were consulted about their care needs and about the overall service being delivered. Resident' meetings were held monthly and there was a good level of attendance by residents. Records indicated that issues raised at these meetings were addressed such as suggestions for food and activities. Advocacy services were available for residents and the provider had prepared a residents guide, as per regulatory requirements.

## Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Visiting was not restrictive and their were suitable communal facilities available for residents to meet with their visitors.

Judgment: Compliant

## Regulation 12: Personal possessions

There were adequate arrangements in place for the management of residents personal possessions. Each resident had sufficient space for storing personal possessions including wardrobe space, a chest of drawers and a bedside locker with a lockable drawer. There were effective systems in place for the return of residents clothing following laundering. Bed linen and towels are laundered by an external laundry company.

Judgment: Compliant

## Regulation 13: End of life

Residents' care preferences for their end of life were discussed with them and recorded in their care plan and there was evidence of general practitioner and specialised palliative care services involved in residents care at end of life. Residents spiritual preferences were recorded and residents received spiritual care from the local priest. There was access to single bedrooms in the centre to ensure privacy and dignity at end of life.

Judgment: Compliant

## Regulation 17: Premises

Areas to be addressed pertaining to the premises to ensure it complied with Schedule 6 of the regulations included the following:

- walls on corridors throughout the centre were stained from alcohol gel, which was unsightly.
- paint on some doorways was cracked and chipped.
- residents in twin rooms were separated by disposable curtains, which made the bedrooms appear clinical in nature.
- there was very limited decor on the corridors of each of the units, which made areas of the centre feel clinical as opposed to homely.

Judgment: Substantially compliant

## Regulation 18: Food and nutrition

Residents were offered a varied nutritious diet. The quality and presentation of the meals was good and residents spoke positively about the food. Some residents required special diets or modified consistency diets and these needs were met. The daily menu was displayed and choice was available at every meal. Residents spoken with were complimentary regarding the quality and choice of food. There was good evidence of regular review of residents' by a dietitian and timely intervention from speech and language therapy when required. Systems were in place to ensure that residents received correct meals as recommended by speech and language therapists and dietitians.

Judgment: Compliant

## Regulation 20: Information for residents

The registered provider had prepared and made available to residents a guide in respect of the centre. This contained all information as specified in the regulations.

Judgment: Compliant

## Regulation 27: Infection control

Action was required to ensure that the provider had procedures in place that were consistent with National Standards for Infection Prevention and Control in Community Services (2018). Issues to be addressed included:

- the storage of residents furniture such as armchairs in en-suite bathrooms.
- there were not suitable facilities for the disposal of household waste water and this was being disposed of in the sinks of sluicing rooms, which increased the risk of cross contamination.

Judgment: Substantially compliant

## Regulation 29: Medicines and pharmaceutical services

Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the

Pharmaceutical Society of Ireland. Medication administration charts and controlled drugs records were maintained in line with professional guidelines.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Significant action was required in individual assessment and care planning to ensure that residents documentation reflected their care requirements and could direct care delivery. For example:

- on review of a sample of residents assessment tools it was evident that some did not contain accurate information with regards to the resident. For example; an assessment to identify the risk of malnutrition did not take into account the residents medical diagnosis which formed part of the assessment. Therefore, this resident was assessed as a low risk when they were a high risk.
- a resident with a super pubic catheter did not have their care requirements identified in their care plan.
- a residents living in the centre for over two months did not have a detailed care plan with regards to their mobility and communication, both which they required support with.
- two residents with responsive behaviors did not have information in their care plan to direct care and these care plans had not been updated when their care requirements changed or their had been input from external agencies.
- some assessments and reviews of care plans were not completed four monthly, which is a regulatory requirement.
- a resident who required a monthly assessment with regards their nutritional status did not have this completed.
- some information in care plans was not specific to the individual resident but included generic instructions pre populated from the electronic care planning system. Therefore, it was not applicable to residents care.
- information in some care plans was outdated and no longer relevant to the residents care requirements.
- a resident requiring skin monitoring, post a procedure, did not have their care plan updated to reflect this.

Judgment: Not compliant

## Regulation 6: Health care

This inspection found that a high standard of evidence based nursing care, in accordance with professional guidelines, was not always provided in the centre, for example:

- a resident who was at high risk of the development of pressure ulcers and who had a significant history of development and treatment did not have their positioning care plan implemented to ensure that their skin was assessed and monitored.
- a residents who required frequent pain medication to manage their symptoms, was not having their pain assessed to ensure that medication was effective.
- a resident with a subcutaneous line inserted, did not have evidence of this recorded in their notes and there was not evidence that this was being monitored to assess if there was redness, swelling or displacement, for example.
- on review of residents who had experienced falls in the centre, there was not always evidence that their vital signs were recorded as per the centres policy and evidence based nursing practice, to ensure deterioration was noted.
- there was not evidence of sufficient monitoring of the skin of a resident who had recent a procedure.
- a resident exhibiting responsive behaviors did not have their urine tested in a timely manner, as indicated in their care plan, to rule out infection.
- a resident assessed as requiring mouth care three hourly did not have this care implemented.

Judgment: Not compliant

## Regulation 7: Managing behaviour that is challenging

This inspection found that significant action was required to achieve compliance with the regulation, for example:

- there was a high use of restraint in the centre which included 23% of residents allocated bedrails. Restraints observed by the inspector not recognised as restraint included the following: doors within the centre being locked, sensor mats (38%), restrictions to cigarettes for residents and access to communal space for residents on the first floor which had been allocated to staff.
- the inspector observed on day one of this inspection a resident exhibiting responsive behaviors, however, they were not managed or responded to in a manner that is not restrictive. The inspector brought this to the attention of the management team on day one.

Judgment: Not compliant

## Regulation 8: Protection

The provider did not take all reasonable measures to protect residents as evidenced by the following findings:

- the provider acted as a pension agent for four residents in the centre and there was evidence that these pension arrangements were managed via a residents client account, as required. However, the inspector saw that the company money was also stored and lodged into this account so therefore was not for residents only, which is not in line with recommended practices and did not safeguard residents finances.

Judgment: Not compliant

## Regulation 9: Residents' rights

This inspection found that residents rights were not being protected as follows: ?

- the provider had increased the service charge fee by 25% in January 2023. However, their was not evidence that residents had been agreeable to this increase. The provider had initiated this increase for two residents, without an updated contract of care. Some residents could not exercise their rights in relation to finances and were unable to voice their concerns at this increase, due to issues such as cognitive impairment.
- a resident residing in the centre, who the provider acted as a pension agent for, did not receive a statement of their account on a monthly basis. Therefore, they could not exercise their rights in relation to finances as they were not aware of money they had available to them.
- the allocation of communal space on the first floor to staff facilities did not ensure residents had choice, with regards to where they would like to spend their day.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Registration Regulation 4: Application for registration or renewal of registration | Compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Not compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 4: Written policies and procedures | Compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 12: Personal possessions | Compliant |
| Regulation 13: End of life | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and care plan | Not compliant |
| Regulation 6: Health care | Not compliant |
| Regulation 7: Managing behaviour that is challenging | Not compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Willow Brooke Care Centre OSV-0007842

## Inspection ID: MON-0040908

## Date of inspection: 27/07/2023

**Introduction and instruction**
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
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| Regulation 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>1. Nursing management to complete an audit of the resident's care plans to ensure individual assessment and care plans reflect the residents individual care requirements and of healthcare, to ensure it is in accordance with professional guidelines. An action plan to be developed following this audit and staff training on care plans provided for all Nursing Staff by the 30th of September 2023.<br>2. Nine newly recruited staff completed further manual handling training on the 12th of August 2023<br>3. All new staff will complete manual handling training prior to commencement of employment.<br>4. The training matrix will be reviewed monthly by the PIC/ADON & HR Administrator and the training schedule updated accordingly, to ensure mandatory training is completed. | |
| Regulation 21: Records | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 21: Records:<br>1. Staff files reviewed to ensure correct references are in place.<br>2. An audit of resident's documents to be completed and actioned, to ensure that resident unique identifiers are on all records, in line with professional guidance.<br>3. This audit will be added to the master audit schedule to ensure ongoing compliance. | |

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Following the inspection, a full review of the system in place to monitor and protect resident finances has been completed. The RPR and Director of Quality & Safety met with the Financial Controller, to clarify that only monies belonging to the Residents of whom we are pension agents should be in the client accounts. This has been actioned by the financial team.
2. The auditing system introduced to the group in 2022 was not implemented in total. This has been reviewed and updated to ensure deficits and risks in the service are identified and managed accordingly.
3. Nursing management attend morning shift handovers and conduct regular walk arounds within the centre to support staff and oversee care provision. A record of these walkabouts to be kept and signed off by the PIC/ ADON daily going forward.
4. Monthly Clinical KPI's are recorded and QIPs developed and actioned accordingly, then discussed at staff meetings and at the monthly Providers Meeting and any education or training needs identified provided for staff to improve practice.
5. A report on agency Nursing staff procurement by the HR Manager demonstrated that all agency staff have current PIN numbers, Garda Vetting and safeguarding training completed.
6. The incident management system is part of a tested electronic system used in all the Centres. It was agreed with the Management team, the RPR and the Director of Q&S that incidents that are reported at handover are to be reviewed and investigated by the PIC/ADON/CNM within a 24-hour window of the incident occurring to ensure timely oversight, opportunities for learning are identified and improvements to the service in place.
7. Incident management training on HSELand to be completed by all managers in the Centre by 30th of September 2023

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| Regulation 24: Contract for the provision of services | Not Compliant |

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
1. Resident's Contracts of Care to be updated to reflect the current service charge and the services provided with this charge.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Repair and painting of walls and doors is part of the ongoing maintenance schedule and is reviewed monthly by the PIC and Dir of Quality & Safety.
2. Décor in the Centre is being updated by the recently appointed Facilities Manager, who oversees the maintenance persons work, in consultation with the Residents as part of their Resident meetings, to ensure a more homely feel to the centre in line with the Resident's wishes.

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| Regulation 27: Infection control | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Staff have been advised not to store Resident's furniture in the en-suite bathrooms. This message is conveyed at shift handover.
2. Suitable facilities are provided for the disposal of household wastewater.

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| Regulation 5: Individual assessment and care plan | Not Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1. The RPR, the Director of Q&S and the PIC met with nursing management to discuss the inspector's findings on the care plans.
2. An Audit of all Resident's Care Plans is ongoing currently by the PIC/ADONs/CNMs and is to be completed by the 30th of September 2023, updated and an action plan agreed to ensure compliance with Regulation 5 going forward.
3. This audit is to be added to the master schedule and completed 4 monthly.
4. Training to be provided by the CNMs for Nursing Staff on accurate assessment and care planning.
5. A Named Nurse system is to be implemented with oversight by the ADONs/CNMs
6. A Keyworker system for the HCAs to be implemented to allow a more inclusive HCA role in assessment and planning of care.

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| Regulation 6: Health care | Not Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:
1. The RPR, the Director of Q&S and the PIC met with nursing management to discuss the inspector's findings on healthcare and agreed that the Managers on duty will provide more oversight on the floor at a minimum of three times daily to ensure a high standard of evidenced based nursing care is provided.
2. The PIC met with Nursing staff following the inspection on the 26th of July 2023 to discuss the findings of the Inspector and the following immediate actions completed:
a) All residents at risk of developing pressure ulcers had their positioning care plans reviewed and updated, to ensure timely positional changes provided by staff.
b) Pain assessments completed for residents who complain of pain and require pain relief before and after the provision of pain relief medication to ensure effectiveness of medication and comfort of Resident.
c) The resident with a subcutaneous line has documented evidence of ongoing assessment of the site.
d) All staff to be familiar with the Falls Prevention policy and sign that they are aware of the post fall protocol. CNMs to audit the management of the previous month's falls and discuss the findings and required action at the next Falls committee meeting and feedback to the quality & safety meeting.
e) To have increased oversight of residents with recurring care needs, ie. Skin integrity issues due to medical condition, ongoing pattern of responsive behaviors or increased need for oral care, by implementation of the Named Nurse and Keyworker System.
3. An Audit of all Resident's Care Plans is ongoing currently by the PIC/ADONs/CNMs and is to be completed by the 30th of September 2023 and discussed at the next Provider's meeting. This will be repeated 4 monthly.

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| Regulation 7: Managing behaviour that is challenging | Not Compliant |

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
1. It is the policy of Willow Brooke Care Centre to provide a safe restraint free environment for all its Residents.
2. All staff have received training in restrictive practices and managing behaviours that challenge.
3. An MDT Committee for Restrictive practices has been set up to ensure that the least restrictive practices are in place in accordance with national policy as published by the Department of Health.
4. PIC/ADON has reviewed the Residents who exhibit responsive behaviours, to ensure

that the appropriate care to support physical, psychological and social care needs are met in a manner that is not restrictive. This review is communicated with staff at daily handover.

| Regulation 8: Protection | Not Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
1. Following the inspection, a full review of the system in place to monitor and protect resident finances has been completed. The RPR met with the financial controller, to clarify that only monies belonging to the Residents of whom we are pension agents should be in the client accounts. This has been actioned by the financial team. A monthly audit of the client account will be completed to ensure compliance with this instruction. We currently have 4 residents for whom we are pension agents. The financial controller has committed to carrying out a full bank reconciliation for each of the residents at the end of every month. The balance in the client account will be equal to the resident's funds and an individual statement will be issued to each resident monthly.

2. The Independent Advocacy service have been engaged to ensure the rights of the 4 residents of whom we are acting as pension agents are upheld in accordance with the guidance from the Department of Social Welfare.

| Regulation 9: Residents' rights | Not Compliant |
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. The yearly service charge increase is communicated by letter to all residents or their advocates prior to the implementation of the increase as per the terms and conditions of the Contract of Care section 3
2. The Contracts of Care for residents are currently being updated.
3. The Independent Advocate for the Resident residing at the Centre of whom the RPR is pension agent, is fully informed of the rate increases, the new contract of care for the resident and is satisfied that the resident's rights are protected at this time.
4. The communal space on the first floor ensures that the Residents have choice with regards where they would like to spend their day

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
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| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training. | Not Compliant | Orange | 30/09/2023 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 26/07/2023 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Substantially Compliant | Yellow | 30/09/2023 |
| Regulation 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by | Substantially Compliant | Yellow | 30/10/2023 |

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| | the Chief Inspector. | | | |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 30/09/2023 |
| Regulation 24(2)(a) | The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned. | Not Compliant | Orange | 31/10/2023 |
| Regulation 24(2)(b) | The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services. | Not Compliant | Orange | 31/10/2023 |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the | Substantially Compliant | Yellow | 31/08/2023 |

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| | prevention and control of healthcare associated infections published by the Authority are implemented by staff. | | | |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | Not Compliant | Orange | 30/09/2023 |
| Regulation 6(1) | The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident. | Not Compliant | Orange | 30/09/2023 |
| Regulation 7(2) | Where a resident behaves in a | Not Compliant | Orange | 30/09/2023 |

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| | manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive. | | | |
| Regulation 7(3) | The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time. | Not Compliant | Orange | 30/09/2023 |
| Regulation 8(1) | The registered provider shall take all reasonable measures to protect residents from abuse. | Not Compliant | Orange | 26/07/2023 |
| Regulation 9(3)(a) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents. | Not Compliant | Orange | 31/10/2023 |