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

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:	20 July 2021
Centre ID:	OSV-0007842
Fieldwork ID:	MON-0033422

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 mart 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 ensuite 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.

Number of residents on the date of inspection:	52

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
Tuesday 20 July 2021	08:30hrs to 16:30hrs	Ella Ferriter	Lead
Wednesday 21 July 2021	09:00hrs to 17:30hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

The inspector met and spoke with several residents during the inspection of Willow Brooke Care Centre. Overall, residents spoke very positively about the staff working in the centre. They told the inspector that staff were very kind and they enjoyed the interactions they had with them. Some residents told the inspector that staff were very busy and there was not always enough staff working in the centre. All residents spoken with stated they were happy living in the centre, and many commented on the bright, clean environment and space in which they were afforded, in their bedrooms and in the communal areas.

The inspector arrived to the centre unannounced for a two day inspection. On arrival, the inspector was met by the receptionist who ensured that all necessary infection prevention and control measures, including hand hygiene and temperature check were implemented, prior to entering the centre. After an opening meeting with the Clinical Nurse Manager, the inspector was guided on a tour of the centre, where they met and spoke with residents in their bedrooms and in communal areas.

Willow Brooke Care Centre is a two story nursing home registered to provide care for 73 residents in the town of Castleisland, County Kerry. It is a purpose built nursing home that was first registered in December, 2020, seven months prior to this inspection. On the day of this inspection there were 52 residents living in the centre. Bedroom accommodation consists of 55 single bedrooms and nine twin rooms, all with en suite facilities. The centre is divided into four wings: Elm, Ash, Chestnut and Sycamore. Bedrooms were decorated to a high standard with ample storage, en suite facilities and flat screen televisions. Some bedrooms on the first floor had balconies, which residents spoke positively about. Residents told the inspector that they liked their living environment, and some had brought in personal memorabilia from home such as pictures and ornaments.

The design and layout of the centre on the ground floor promoted an unrestricted environment for residents, who were encouraged to mobilise freely. This comprised of a large open plan sitting room/dining room, which was the main focal point of the centre for activities and meals. There was comfortable seating and a large flat screen television in one section of this room. One resident was observed streaming country music videos here during the day. There was a second sitting room called the Kingdom Day room, which led out to a secure garden. Residents were observed enjoying spending time in the communal areas on the ground floor, over the two days of this inspection. There were three communal rooms on the first floor. However, two of these rooms were not being used for residents on the days of this inspection. One was allocated to visiting and one was being used by staff. The main sitting room upstairs, the Desmond Day room was homely and nicely decorated. The inspector observed residents sitting here during the day, watching television and being appropriately supervised by staff. Although the activities coordinator did visit residents upstairs, to deliver newspapers and chat with them in the morning, the lack of activity provision was evident on observation, with some residents in the

upstairs sitting room without meaningful activities for parts of the day. The inspector was informed that the provider was currently recruiting for a second activities coordinator, and this role would be filled as soon as possible.

This inspection took place two very warm July days, where external temperatures reached 28 degrees Celsius. Staff were observed providing cold drinks to residents and encouraging them to keep hydrated. There was access to two enclosed gardens that were clean and well maintained. The inspector was informed that outdoor garden furniture had been ordered for these areas and delivery was expected the following week. Residents who chose to sit outside and enjoy the sun had sun cream applied and sun hats provided. Cold fruit smoothies and were offered which residents reported they enjoyed. Residents who enjoyed gardening were observed assisting staff to water flower beds, which were plentiful and well maintained at the front of the building.

Where residents required assistance during this inspection, the inspector observed staff assisting residents in a discrete and sensitive manner at all times. There were lovely interactions between residents and staff, where residents were observed joking, laughing, singing and reminiscing with staff. Staff spoke to residents about their family and upcoming football matches they were looking forward to. Overall, residents were very complimentary about the staff working in Willow Brooke Care Centre. However, three residents told the inspector that there was not always enough staff working, and they often had to wait for their shower in the mornings and for somebody to answer their call bell. The inspector observed on day two of this inspection that bells on the first floor were ringing for long periods. Care staff were assisting residents with meals and were not available to attend to other residents calling for assistance. A review of the rosters by the inspector confirmed that there were insufficient numbers of care staff rostered, when considering the care needs of residents and the size and layout of the centre. The inspector was informed that there had been a large turnover of staff since the centre opened and recruitment was ongoing.

The inspector observed that there was a comprehensive activities programme in place and residents were aware of the days programme. There was a staff member allocated to the role of activity coordinator who was enthusiastic about the role, and it was evident they knew residents personal preferences very well. The inspector saw a number of lively fun filled activities taking place such as garden games and bingo. The in house physiotherapist also facilitated an exercise class on both days of this inspection. Some residents were observed going for walks in the morning with the activities coordinator and physiotherapist. The centre had access to a minibus and had recently had days out to Banna Beach and Muckross House in Killarney. However although the activities coordinator did visit residents upstairs, to deliver newspapers and chat with them in the morning, the lack of activity provision was evident on observation, with some residents in the upstairs sitting room without meaningful activities for parts of the day. The inspector was informed that the provider was currently recruiting for a second activities coordinator, and this role would be filled as soon as possible.

The inspector had the opportunity to observe residents' dining experience over the

two days of this inspection. Residents the inspector spoke with were complimentary about the food served in the centre and confirmed that they were always afforded choice. One resident told the inspector how they looked forward to the home baking daily, particularly the brown bread. The main ground floor dining area was bright and tables were laid out to facilitate social distancing. The chef was visible to the residents and served food carvery style. Food was presented well and appeared wholesome. There were adequate staff to support the residents during meal times as the provider had employed the additional support of two dining room assistants to supervise and assist residents at meal time. However, a review of the dining experience and system of providing meals to residents on the first floor required review. The physiotherapy room was being used as a dining room for residents on the first floor. The inspector observed on day two of this inspection that this room was overcrowded and a resident was observed being advised to wait outside until another resident finished their meal. Residents who chose to have their meals in their bedroom were not always served their meals hot due to the current system in which meals were delivered. The management team agreed to review this following this inspection. These findings were supported by observation of the inspector, a review of feedback from residents and a review of complaints.

The inspector met a number of visitors who were delighted to be able to visit their family member again. Visitors spoke positively regarding the kindness of staff and care their loved one received at the centre. Visitors told the inspector that they found booking visits easy via an online system. They expressed how difficult the restrictions the last few months had been as a result of level five restrictions.

The inspector identified a number of ongoing issues with the governance arrangements in the centre that required action. The residents generally seemed to be unaware of these issues. The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This was a two day unannounced inspection to monitor compliance with the regulations. The findings of this inspection were that immediate improvements were required in the overall governance and management of the service, to ensure effective oversight of this centre. An immediate action plan was issued, on the day following this inspection, to request that assurances be provided regarding the governance and management of the service and fire precautions. Following this inspection a precautionary provider meeting was held on the July 23rd, 2021, and the provider agreed to address the areas of non compliance. Overall, the governance and management of the service required strengthening, and a number of areas for improvement were identified during the inspection which included staffing levels, individual assessment and care planning, training and staff

development, risk management and notification of incidents.

Willow Brooke Care centre was first registered in December 2020 by the Chief Inspector, to operate as a designated centre for older persons. The centre is 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 daily operations of the centre. There was also additional support of an Operations Manager to support the centre.

A new person in charge had been appointed to the role, a few weeks prior to this inspection. Care in the centre is directed through the person in charge, who reports to the registered provider representative. From a clinical perspective the person in charge is supported by two Clinical Nurse Managers, and a team of nurses, healthcare assistants, catering, household, and administrative staff. The staffing number and skill mix of staff on the day of inspection was found not to be appropriate to meet the care needs of the residents, which is discussed further under regulation 15. Management of the centre at weekends, also required review, to ensure that there was adequate supervision resources in place to meet the assessed needs of the residents.

There was evidence of gaps in mandatory training for a large proportion of staff working in the centre. The supervision and induction of newly recruited staff required review as it was found to be inadequate, which is discussed under regulation 16. All records as requested during the inspection were made readily available to the inspector. Records were maintained in a neat and orderly manner and stored securely. However, on review of a sample of staff files it was found that not all complied with the regulatory requirements, which is discussed under Regulation 21. A vetting disclosure, in accordance with the National Vetting Bureau (Children And Vulnerable Persons) Act 2012, was in place for all staff. A directory of residence was not maintained as per regulatory requirements.

Monitoring of the service required significant improvement, as it was found that a system of auditing and monitoring the service had not been established. Key performance indicators were being collected by the person in charge on wounds, antibiotics, restraint and infection. Accidents and incidents were recorded in the centre, however, there was not evidence that appropriate action was always taken and that they were followed up on and reviewed. Some incidents, as per requirements of the legislation, had not been notified to the Chief Inspector, which is further detailed under regulation 31. The centre had a comprehensive complaints policy and procedure which clearly outlined the process of raising a complaint or a concern, however, complaints were not always recorded in line with regulatory requirements.

Overall, this inspection found that there was a requirement for increased oversight and monitoring of the service, by the registered provider and the person in charge to ensure that the service provided is safe, appropriate, consistent and effectively

monitored.

Regulation 14: Persons in charge

A new person in charge had recently been appointed to the centre. They were a qualified nurse with the relevant experience and management qualifications as required by the regulations. They facilitated the inspection in an open manner and demonstrated good knowledge regarding her role and responsibility.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was not appropriate considering the needs of the residents and the size and layout of the designated centre leading to delays in care delivery. Findings of the inspector were supported by discussions with residents, staff and observations on day two of this inspection. In particular:

- There were only seven healthcare attendants rostered to to care for 52 residents on the day of this inspection. Thirty three of these residents were assessed as maximum to high dependency, twelve as medium dependency and seven as low dependency.
- On review of the roster the week prior to this inspection there were four days where there were only six care staff rostered.
- There was one activities coordinator in the centre. Resident's upstairs did not have full access to activities.

Judgment: Not compliant

Regulation 16: Training and staff development

Training records reviewed on the day of the inspection did not provide evidence that all staff had received mandatory training. Gaps were identified as follows:

- 18 staff (26%) did not have training in manual handling.
- 38 staff (54 %) did not have fire training. There was evidence that training was booked for some staff in July 2021.
- 31 staff (44%) did not have safeguarding vulnerable adults training.
- 51 staff (72%) did not have managing responsive behaviour training. This posed a risk to residents in the centre whose assessed needs included management of complex behaviours.

- A number of staff had commenced work in the centre without having undertaken training on infection control (44%) and hand hygiene (59%), which posed an increased risk due to the COVID-19 pandemic.

The inspector was not assured that staff were appropriately supervised and that there was a robust induction process for registered general nurses (RGNs). There was not evidence in personnel files of an appropriate induction programme for two newly recruited RGNs. From review of rosters and from discussion with management, it was evident that there was not appropriate levels of supervision in place. Supervision arrangements for staff at weekends also required review, as it was found that there was not always a manager rostered at weekends.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had not established or maintained a directory of residence in the centre.

Judgment: Not compliant

Regulation 21: Records

A sample of six staff files were reviewed by inspector. Records were well maintained and stored securely. However, not all staff files were kept in accordance with schedule two of the regulations as it was found:

- One file did not have a second reference from an employer.
- One file had a statement of employment as opposed to a reference.
- One file had a reference from a college as opposed to an employer.

Judgment: Substantially compliant

Regulation 23: Governance and management

A number of issues were identified with the governance and management of the centre. The governance arrangements in place did not ensure the effective delivery of a safe, appropriate and consistently monitored service. Issues pertaining to the governance arrangements included:

- The designated centre did not have sufficient resources to ensure effective

delivery of care in accordance with the statement of purpose. For example there were only seven registered general nurses available to the roster and 36 health care attendants. This was contrary to the statement of purpose and was not sufficient to provide nursing and care staff over a 24 hour a day, seven day a week service of this size.

- Although there was a defined management structure in place, there was a gap in the management structure, as an assistant director of nursing had not been recruited.
- There was evidence of a lack of effective systems in place to monitor fire precautions, staff training, care planning, medication management, notification of incidents, and complaints which are all outlined further under the specific regulations.
- There was insufficient monitoring of resident dependency levels, which were found to be inaccurate on day one of this inspection. This information is required to inform resources required in the provision of residents care.
- There was not an auditing system established to monitor the service. This included a lack of trending of accidents and incidents to improve safety for residents.
- Medication errors within the centre were not found to be not appropriately investigated and actioned.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications had not been submitted for incidents specified in the regulations relating to:

- two incidents resulting in residents transfer to hospital.
- an incident relating to staff professional misconduct.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints log was reviewed and evidenced that formal complaints were recorded, however, there was not always evidence that residents and relatives were satisfied with measures put in place in response to issues raised.

Judgment: Substantially compliant

Quality and safety

Overall, residents' wishes and choices regarding their care and quality of life were respected and there was good access to medical and nursing care. However, this inspection found that the quality and safety of resident care was compromised due to insufficient oversight by management, inadequate management of fire precautions, poor risk management systems and a care planning system that did not fully direct residents specific care needs.

Residents had access to appropriate medical and allied health services. There was evidence of regular medical reviews and referrals to specialist services as required. There was a low incidence of pressure ulcer development and evidence of good wound care practices. The centre employed a physiotherapist full time. Access to geriatricians, palliative care, community mental health services, dietetics, and speech and language therapists were readily available. 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. Some issues for improvement, in relation to medication practices in the centre that required attention are detailed under regulation 29.

The centre had an electronic resident care record system. Residents were assessed using standard assessment tools, and care plans were developed. However, on review of a sample of these documents it was found that information was not always accurate, therefore, could not easily direct care. This is discussed further under Regulation 4. The inspector was satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in the centre. This was evidenced by conversations with staff and involvement of the multidisciplinary team, however, some residents did not have end of life care plans, to provide information on personal preferences and support care delivery.

This inspection took place during the COVID-19 pandemic. The centre had experienced a small outbreak in December 2020, where two staff had tested positive for COVID-19. This had not effected residents living in the centre. Daily symptom monitoring of residents and staff for COVID-19 continued. Staff were observed to have good hand hygiene practices and correct use of PPE. Sufficient housekeeping resources were in place and the centre was found to be clean to a very high standard throughout. However, the facilities for staff changing required review, to reduce risk of transmission of infection, which is discussed further under regulation 27.

Residents had access to radio, magazines, newspapers and televisions. Some areas regarding residents rights required to be addressed which is discussed further under regulation 9. Residents were offered visits in line with current COVID-19 visiting guidelines and were encouraged to maintain contact with families through various

means such as video calls and telephone.

Immediate action was required in relation to fire precautions as it was found that the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. The registered provider was issued with an immediate action to address this risk following this inspection. This is further detailed under regulation 28. There was a risk management policy in the centre and a risk register monitored by the person in charge. However, the risk management policy was not seen to be followed in practice, in relation to the investigation and learning from incidents and frequency of review.

Regulation 11: Visits

Indoor visiting was taking place in line with Health Protection and Surveillance Centre (HPSC) guidelines. Visiting areas had been set up which enabled safe visiting, while abiding to social distancing guidelines. Visitors booked in advance on line and were appropriately screened on arrival. Residents also kept in touch with their families via telephone video conferencing, mail and other technological means.

Judgment: Compliant

Regulation 26: Risk management

The centre had a risk register that detailed centre specific risks, risk ratings, the controls implemented and an owner of each risk. However, this inspection found that a number of medication errors had occurred in the centre that were not addressed appropriately. There were not arrangements in place for the investigation and learning from these incidents. This had the potential to increase the likelihood of future errors, thus compromising residents safety. The risk register was also not updated monthly, as per the centres policy on risk management.

Judgment: Not compliant

Regulation 27: Infection control

The arrangements in place to protect staff from the occupational risk of acquiring an infection required review. This was in particularly relating to the facilities staff had available in the centre to change into uniforms at the start of shift, and to comply with the centres uniform policy. Space allocated was small and only allowed for two staff to enter the room at one time.

Judgment: Substantially compliant

Regulation 28: Fire precautions

This inspection found that the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. A number of areas of serious concern regarding the adequacy of fire safety precautions in the centre were evident such as:

- From a review of fire drill reports in the centre and assessment of staff knowledge, the inspector was not assured that residents in the largest compartments (11 residents) could be safely evacuated at all times during the day and night by staff, and in a time that ensures the safety of residents and staff. Following the inspection an evacuation drill record was submitted demonstrating a good evacuation time. Further drills are required to ensure all staff are competent and confident in safe and timely evacuation.
- There were no arrangements in place for reviewing fire precautions and testing fire equipment. Review of records indicated that daily and weekly fire checks were not taking place in the centre since it was first registered.
- Up-to-date service records were not available for the maintenance of the fire equipment detection, fire alarm system and emergency lighting.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The following issues pertaining to medication management required to be addressed:

- some medication in the refrigerator was not labelled with the date in which it was opened, therefore, administration within the expiry date could not be assured.
- the controlled drug press in the centre was not locked within a locked press as per the requirements for safe storage of medications. The person in charge arranged for a lock to be fitted on day 2 of this inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvements were required in the individual assessment and care planning for residents to ensure care plans were sufficiently detailed to direct care. This was evidenced by the following findings:

- Not all care plans were updated four monthly or updated contemporaneously to reflect the changing needs of residents.
- Some care plans were generic and not specific to the residents care needs.
- End of life care plans did not always reflect the individual wishes and personal preferences of residents.
- Residents with behaviors that challenge did not always have a care plan to direct care.

The management team acknowledged the deficit in care planning documentation and informed the inspector that they were currently in the process of reviewing all care plans.

Judgment: Not compliant

Regulation 6: Health care

Residents had timely access to general practitioners (GPs), specialist medical and nursing services including psychiatry of older age, community palliative care and tissue viability specialists as necessary. Allied health professionals provided timely assessment and support for residents as appropriate. There was a full time physiotherapist working in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. However, there was not sufficient staff allocated to activities to accommodate residents living on the first floor. The method for consultation with residents via residents meetings also required review. Records evidenced that one residents meeting had taken place since the centre opened. This was contrary to the centres statement of purpose which stated that residents would be consulted every three months. It was also noted that where suggestions and recommendations were made by residents, there was not evidence that they were always actioned and that there was oversight by the management team.

Judgment: Substantially 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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Willow Brooke Care Centre OSV-0007842

Inspection ID: MON-0033422

Date of inspection: 21/07/2021

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**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Interviews held and recruitment process commenced on week beginning 09.08.2021. HR department is leading same. HR department continues to advertise positions for HCAs and Nurses for Willow Brooke. • Minimum HCA on duty during the day has been maintained at 8.5/9 HCAs per day. Senior Healthcare Assistants have been appointed to support oversight. • Meeting held with RP and HR manager on 04.08.2021. Agreement to block book agency nurses for the month of August and September until recruitment of staff nurses are complete. This will also allow for support and monitoring of existing nurses and to ensure preceptorship is complete. • Assistant Director of Nursing position will be temporarily filled by CNM1. Acting Assistant Director of Nursing contract put in place • CNM1 position temporarily filled by senior staff nurse. Acting CNM1 contract put in place 09.08.2021. • Acting ADON will be working in a supernumerary role. • Clinical team (DON, ADON and CNM) to meet once weekly. This will ensure that goals are met. • Activities Assistant Role continues to be advertised.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Mandatory training has commenced and further training has been booked for staff and schedule for same is communicated with staff in advance. This is also built into the staff	

members' roster.
• Further training is provided to support staff members c/o physiotherapist, TVN and Dementia care nurse.
• Training Matrix has been changed to allow for mandatory training to be updated easily. This has been allocated to Admin staff.
• Newly recruited staff members are advised to complete infection control training and hand hygiene training prior to commencement of employment. Certificates to be provided.
• Induction process has been updated. Staffing has been increased to support same. Access to agency staff has been allowed. Training to support staff has commenced.
• Assurances provided to inspector on the 05.08.2021.
• Registered provider is advertising to recruit a Training and Development Officer for Windmill Group.

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
• Directory of Residents has been updated. This is maintained by Admin staff. PIC will oversee same.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Staff Records maintained by allocated Admin staff. HR department to support same. HR department will also support staff during recruitment of staff to ensure compliance.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Recruitment has commenced for 2 WTE nurses. Start dates have been agreed. Further interviews held on week commencing 16.08.2021. 2 x candidates were

successful.
• HR department continues to advertise posts.
• Agreement to block book agency nurses for the month of August and September until recruitment of staff nurses are complete. This will also allow for support and monitoring of existing nurses and to ensure preceptorship is complete.
• Acting ADON and Acting CNM posts in place. 2 x candidates have applied for ADON position. HR department liaising with both candidates. Interviews will be arranged in month of September (due to availability of candidates).
• Operations Manager has assisted and supported PIC in getting systems in place for monitoring of fire precautions.
• Training Matrix updated and same monitored and updated by allocated Admin staff. Staff training has commenced and same booked in advance.
• Appointment of Acting ADON and CNM with the support of agency nurses has allowed for oversight of care planning and medication management.
• Pharmacy carried out audit for medication management on week commencing 23.08.2021. The actions for these discussed with management team.
• Auditing system to be carried out on Xyea system. Management team in place which allows for allocation of responsibility. Audit schedule commenced.
• Dependency levels monitored by CNMs on the 1st of the month.
• Actions taken and appropriate follow up for medication errors. Pharmacy carried out medication management audit in August. Actions to be taken by management team.
• Medication competency assessments carried out for all nurses.
• Medication management training on HSEland is mandatory for all nurses.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Notifications submitted to HIQA after inspection report. Incidents were documented appropriately on Xyea system. Notifiable incidents to be submitted by PIC in a timely manner.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints are documented on Xyea system. PIC to review same in a timely way. PIC to document that residents and relatives are satisfied with measures put in place in response to issues raised.

Regulation 26: Risk management	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management: Risk Register is documented on Xyea system. Risk Register to be reviewed by PIC/ADON on a monthly basis. This is built into a schedule for the management team.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: Staff are offered the use of another room for changing facilities. Registered Provider to discuss the changing facilities with Maintenance Department in order to get a long-term solution to same.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire training for all staff commenced. Evacuation drill for the largest department has taken place. This is continued to ensure all (day and night) staff have taken part in evacuation drill. A record of same is maintained. Fire folder commenced. This has daily, weekly and monthly checks as per HIQA document.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and	

pharmaceutical services: Labels provided and placed in drug trollies. These are provided by pharmacy. Nurses advised to use same. This was discussed at monthly meetings. This is monitored by CNM.

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: Management team in place. Improvements made to care planning. This is monitored by CNMs and ADON with oversight from PIC. Named Nurse system in place and allows for a more individual care plan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Activities assistant post advertised. HR department is leading same. This has been advertised both internally and externally. Monthly meetings take place for residents. Template made up for actions and who is responsible for same. This ensures that there is evidence of follow up of same.

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
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	23/07/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/10/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/08/2021
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Not Compliant	Orange	31/08/2021

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 the Chief Inspector.	Substantially Compliant	Yellow	31/10/2021
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	23/07/2021
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	Red	23/07/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events	Not Compliant	Orange	31/08/2021

	involving residents.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/08/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	22/07/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	22/07/2021
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Red	22/07/2021
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably	Not Compliant	Red	22/07/2021

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	21/07/2021
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	23/07/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Yellow	31/08/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and	Substantially Compliant	Yellow	31/07/2021

	effective complaints procedure which includes an appeals procedure, and shall 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.			
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	30/09/2021
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/11/2021
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and	Substantially Compliant	Yellow	31/08/2021

	participate in the organisation of the designated centre concerned.			