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: | Willowbrook Lodge |
| Name of provider: | NSK Healthcare Limited |
| Address of centre: | Mocklershill, Fethard, Tipperary |
| Type of inspection: | Unannounced |
| Date of inspection: | 24 February 2021 |
| Centre ID: | OSV-0000302 |
| Fieldwork ID: | MON-0030526 |

## About the designated centre

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

Willowbrook Lodge is located just three miles from Cashel on the Fethard Road. The centre is a two storey facility with accommodation for 26 residents. There is accommodation for nine residents on the ground floor and 17 residents on the first floor. Accommodation comprises 10 single bedrooms, five twin rooms and a three bedded room on each floor. Some rooms have en suite facilities. The communal rooms are mainly on the ground floor and there is a large communal room on the first floor which offers vistas of the surrounding countryside. The service caters for the health and social care needs of residents both female and male, aged 18 years and over. Willowbrook Lodge provides long term care, dementia care, respite care, convalescent care and general care in the range of dependencies low / medium / high and maximum. The service provides 24-hour nursing care.

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

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| Number of residents on the date of inspection: | 19 |

## 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 |
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| Wednesday 24 February 2021 | 09:40hrs to 17:40hrs | Caroline Connelly | Lead |
| Wednesday 24 February 2021 | 09:40hrs to 17:40hrs | Niall Whelton | Support |

## What residents told us and what inspectors observed

The overall feedback from residents was that the person in charge and staff were kind and caring and that they were happy living in the centre which was homely and met their needs. Inspectors met the majority of the residents during the inspection and spoke in more detail with seven residents throughout the day

On arrival to the centre, inspectors were met by a staff member who ensured that all necessary infection prevention and control measures, including hand hygiene and temperature checking were implemented prior to accessing the centre. Inspectors were guided on a tour of the centre by the person in charge. Inspectors saw that there had been numerous improvements in the decor and furnishings of the centre since the previous inspection. Old carpets had been removed and new flooring had been installed in bedrooms, communal areas and in corridors. Most areas of the centre were freshly painted and new curtains and furnishing had been purchased and installed. Bedroom furnishings that were in poor repair on the previous inspection had been replaced or repaired. However, the inspectors saw that in a number of bedrooms there was only a single wardrobe which did not provide adequate storage and hanging space for residents clothing. Overall, the centre was seen to be much brighter and cleaner throughout.

Inspectors identified a number of ongoing issues with fire safety during the inspection, some of which necessitated an urgent action plan response. Some of these had been identified on the previous inspection and actions to rectify the issues had not been completed. Reassurances were received following the inspection from the provider that these urgent actions were addressed. These issues are further detailed in the report under Regulation 28 Fire Precautions.

It was very evident from the walk around with the person in charge that she was well known to all residents as she stopped to talk to residents on the way around the centre. All of the residents who spoke to inspectors were complimentary of the service provided and described the staff as kind, caring and obliging. A number of residents said staff will do anything for you and another resident said they "wouldn't have anyone say a bad word said about any of the staff in Willowbrook . The inspectors observed resident and staff interactions throughout the day and observed kind and caring interactions. It was obvious that staff knew the residents well and vice versa. The inspectors overheard one resident requesting two cups of tea one for her and one for the staff member to have with her while they chatted. Residents told the inspectors they were grateful to the staff for all the care they received during the pandemic and they were very relieved that they had received their COVID-19 vaccines.

The inspectors observed that residents' choice was respected and control over their daily life was facilitated in relation to whether they wished to stay in their room or spend time with others in the sitting rooms, where they could observe social distancing. Inspectors observed that there were a number of areas where residents

could sit and walk outside the centre. The 'memory garden' to the front of the building included plants and shrubs, while a large, brightly-painted mural and comfortable seating were featured in the secure area at the rear of the premises. Residents told the inspector that they enjoyed sitting out during the fine weather and garden furniture was available for their comfort.

There was a staff member in the role of activity coordinator who was well known to the residents. However this staff member worked as a care staff in the morning so activities generally only took place in the afternoons. The inspectors observed different activities taking place during the inspection. Social distancing was seen to be maintained in the day rooms. During the activities, the staff were observed to bring out the best in residents encouraging them to participate in the activities. A number of residents said the mornings could be quiet and the inspector observed that there was less activities going on in the mornings. Residents were observed reading newspapers and watching TV other residents were exercising using specialist strengthening equipment.

Residents were complimentary about the food and the inspector saw that residents were offered choice and the food was wholesome and nutritious. Inspectors saw frequent tea and drinks rounds during the day including the addition of resident's favourite biscuits. Inspectors saw that this information was included in some of the residents care plans and in a document "a little bit about me" that was completed for all residents. This identifying residents likes and dislikes and their social preferences such as one resident loves horse racing etc. Inspectors observed that the environment in the communal spaces was generally homely and efforts were made to ensure social distancing in the day room and conservatory by the removal of furniture and spacing of chairs. Tables in the dining room had been spaced out and two residents could sit at each table. The centre was set in a rural location and there were lovely views out to the countryside from most rooms in the centre and particularly the day room upstairs which provided panoramic views of the local area.

Residents said they were aware of COVID-19 and the effects of it and regularly discuss it with the person in charge and the staff. They were made aware of visiting restrictions and a number of residents said they had missed their families as level five restrictions had been imposed with no internal visitors. However, residents told inspectors they spoke to their families via phones, What Sapp and other forms of technology. Visiting on compassionate grounds was also facilitated. Improvements in infection control were seen throughout the centre and inspectors observed that staff abided by best practice in the use of PPE and good hand hygiene was observed by all staff. The centre was observed to be clean throughout and the increased cleaning hours for cleaning staff on duty was evident. A review of the storage space within the centre was required as this was limited in some areas leading to trolleys etc. stored on the corridors. Resident bedroom accommodation was provided in a mixture of single bedrooms, twin bedrooms and three bedded rooms. Directional signage was pictorial as well as written; this assisted residents with cognitive difficulties to find areas of the centre. Hand rails were available on corridors to maintain resident’s safety and mobility needs. However, inspectors observed loose wires from TV and electrical appliances and unsecured window blind cords that required securing for the safety of residents. The stair lift frame came out beyond

the bottom of the stairs into the hallway and presented as a trip hazzard for anyone walking past. The inspectors were assured as the centre had a new passenger lift this stair lift was to be removed.

Overall, the residents that inspectors spoke with expressed feeling content in the centre. Staff spoken with stated that they were well supported by management. 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

The centre had a history of poor compliance found on the previous inspection of the centre undertaken on 04 august 2020 and this unannounced risk inspection was undertaken to follow up on actions required from the previous inspection. This inspection had a particular focus on fire safety and findings showed that significant fire safety risks remained evident in the centre necessitating an immediate action plan.

On foot of the findings at the previous inspection in August 2020, the Chief Inspector requested the Provider to arrange for a fire safety risk assessment of the centre. A fire safety assessment was carried out by a fire safety consultant in October 2020, however at this inspection none of the recommendations of that report had been addressed, nor was there a plan in place to address them.

There were improvements seen in a number of areas such as infection control, in the decor and repair of the premises and staffing levels and staff training since the previous inspection. However, at the time of the inspection the provider had not taken all the necessary measures to ensure that the service was safe, appropriate, consistent and effectively monitored. There were ongoing non-compliance's identified with fire safety and inspectors issued urgent action plans to the provider in relation to these issues. A referral was also made to the fire authority. Reassurances were received from the provider within the required time frame that the immediate risk had been rectified. However there were a number of ongoing risks that required action as soon as possible.

The centre is owned and operated by NSK Healthcare Limited and the management structure consisted of the registered provider, a limited company which has two directors who were responsible for the running of the centre. They took over the operation of the centre in April 2019. The person in charge is a registered nurse with the required experience of nursing older people. She holds a management qualification and is actively engaged in the governance and operational management of the centre. Following the previous inspection as required the management structure was strengthened by the appointment of a Clinical Nurse Manager (CNM).

The person in charge had increased management time and the CNM will take charge of the centre in the absence of the person in charge. Management meetings had also been reintroduced and are held every two weeks alternating between on-site meetings and zoom meetings. minutes of these meetings were viewed by the inspectors and many of the key operating issues of the service were discussed.

There was evidence of increased auditing of the service since the previous inspection. Audits were seen of care practices including medication management, accidents and incidents, hand hygiene audits, mask wearing audits and cleaning audits. An annual review of the quality and safety of care had been conducted for 2020 and residents views were elicited through residents meetings.

There were 19 residents living in the centre on the day of the inspection. Inspectors acknowledged that residents and staff living and working in centre has been through a challenging time and they have been successful to date in keeping the centre COVID-19 free. Regular swab tests had confirmed all staff to be negative for COVID-19 and a number of the required precautions were in place to prevent infection. Residents and staff had all received COVID-19 vaccinations.

There was a detailed risk assessment policy in place and clinical risks were all assessed. However the inspectors identified a number of additional hazzards that had not been outlined in the risk assessments or policy.

## Regulation 15: Staffing

Staffing hours had increased since the previous inspection. Cleaning staff now worked 9am to 5pm seven days per week. A nurse had been appointed to the role of CNM and acted up in the absence of the person in charge. The person in charge had increased management hours. Overall staffing levels seen during the day of the inspection and based on the currently assessed needs of the residents appeared sufficient to meet the needs of the residents. Staffing levels at night were to be kept under review as there were only two staff on duty for the current 19 residents over two floors. The person in charge assured the inspector this was under constant review.

Judgment: Compliant

## Regulation 16: Training and staff development

Training in infection prevention and control, including hand hygiene and the donning and doffing of PPE was provided through online training. A record was maintained of

staff attendance at theses mandatory training sessions.

There was evidence that newly recruited staff had received an induction with evidence of sign off on key aspects of care and procedures in the centre. A training matrix for other ongoing training was in place and made available to the inspectors. Mandatory training in fire safety, moving and handling and safeguarding was in place and up to date for staff and further training was scheduled. Newly recruited staff had undertaken further online training and in house training had been provided in the interim in safeguarding and fire safety whilst they waited external trainers.

Judgment: Compliant

## Regulation 21: Records

Requested records were made available to inspectors and were seen to be well maintained. A sample of staff files viewed met the requirements of Schedule 2 of the regulations, for example they contained the required references and qualifications. Evidence of active registration with the Nursing and Midwifery Board of Ireland was seen in the nursing staff records viewed. Garda Vetting disclosures were in place for staff prior to commencing work in the centre.

Judgment: Compliant

## Regulation 23: Governance and management

Inspectors identified that the provider continued to lack oversight of the centre and adequate resources were not allocated to the centre to ensure the safety of the residents. The provider had not addressed all the non-compliance identified on the previous inspection to the satisfaction of the Chief Inspector and systems were not implemented to address a number of issues identified.

- Despite assurances received from the provider in relation to fire safety, many of the actions required from the previous inspection in relation to fire safety, remained outstanding on this inspection. These issues are outlined under regulation 28 Fire precautions.
- Management systems had not been implemented to address risks identified in the centre

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

Contracts of care had been updated following the last inspection and were now seen to meet the requirements of legislation. They included the room to be occupied and set out the terms of residents' accommodation in the centre.

Judgment: Compliant

## Regulation 34: Complaints procedure

An effective complaints procedure was in place in the centre. This procedure was prominently displayed in the main entrance area. The complaints procedure identified the nominated complaints person and summarised the appeals process in place. The complaints log was reviewed by inspectors. This was maintained separately from the resident's individual care plan in line with regulatory requirements. All documented complaints had been dealt with appropriately and had sufficient detail of the investigation conducted. The responses and satisfaction of the complainants were documented.

Judgment: Compliant

## Quality and safety

Overall, residents were supported and encouraged to have a good quality of life which was respectful of their wishes and choices. There was evidence of good consultation with residents and their needs were being met through good access to healthcare services and opportunities for social engagement. However, issues with fire safety remained a serious concern and further improvements were required with risk management and premises.

Resident'/s healthcare needs were well met and there was a choice of General Practitioners' (GP's) that supported the centre. Based on a review of a random sample of care plans; the inspectors found that care plans were person centered and there were very comprehensive end of life care plans seen.

Inspectors noted that the decor of the premises had been upgraded since the previous inspection and was more welcoming and homely. There was an ongoing programme of proactive maintenance and further works were scheduled such as the continuation of the replacement of flooring and ongoing painting of areas that had not been redecorated to date. The premises generally met the needs of the residents in a homely and comfortably way. There was adequate communal and

private accommodation but the requirement for an additional storage space for residents and equipment was evident.

Although there had been some improvements in fire safety since the previous inspection which included the provision of fire training and regular fire drills, at the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. There are a number of areas of concern regarding the adequacy of fire safety precautions in the centre and significant improvements were required to comply with the requirements of the regulations to ensure that residents and staff were adequately protected from the risk of fire.

Improvements were seen in infection and control throughout the centre. A local COVID-19 management team had been established within the geographical area and the person in charge was involved in these meetings. There was a clear and comprehensive COVID-19 emergency plan and policy in place which the inspectors reviewed. The management team had a clear list of the relevant persons to contact in any emergency situation. The centre had been divided into two different areas. Residents returning from the acute hospital who required 14 days isolation, self-isolated in a single room with en-suite facilities. Social distancing was put in place throughout the centre. Up to date training had been provided to all staff in infection control, hand hygiene and in donning and doffing of PPE. Regular staff briefings took place to ensure staff were familiar and aware of the ongoing changes to guidance from public health and the HSE. The person in charge said she met with staff and residents on a daily basis and informed them of ongoing changes.

The effects of social isolation had been individually assessed for each resident and suitable alternatives implemented to ensure the residents remained connected with their families. Staff were found by the inspector to be very knowledgeable about resident's likes, past hobbies and interests which were documented in social assessments and care plans so that they could provide social stimulation that met resident's needs and interests. There were systems in place to safeguard residents from abuse and training for new staff was ongoing. All staff had a valid Garda vetting disclosure in place prior to their commencement of work in the centre.

## Regulation 11: Visits

There were a number of visiting areas available throughout the centre and in the grounds of the centre. However currently due to COVID-19 level 5 restrictions, visiting was not allowed except for in compassionate circumstances. The person in charge outlined the plans in place for reopening to visitors on a phased basis maintaining social distancing as restrictions on COVID-19 were lifted.

Judgment: Compliant

## Regulation 17: Premises

There were some issues identified with the premises during the inspection that required review.

- Lack of suitable storage was evident throughout the building. Storage rooms were seen to be cluttered and bathrooms and corridors were inappropriately used to store linen trolleys and other equipment.
- In a number of bedrooms the inspectors saw that there were only single wardrobes which did not provide adequate storage space for residents clothing as a bag of clothing was seen on top of a wardrobe.

Judgment: Substantially compliant

## Regulation 26: Risk management

The inspectors identified a number of hazards during that had not been risk assessed and included in the risk management policy.

- Loose wires were seen to hang down from televisions and around sockets that could be ligature points and trip hazzards.
- The stair lift frame came out beyond the bottom of the stairs into the hallway and presented as a trip hazzard for anyone walking past.
- Window blind cords were seen to be hanging loosely and were easily accessible to residents. These could be used as a ligature and required attention.

Judgment: Substantially compliant

## Regulation 27: Infection control

Since the previous inspection there had been numerous improvements in infection and control in the centre. A full assessment of the premises from an infection control perspective was undertaken by the infection control specialist for the HSE and all recommendations had been implemented.

Infection control training was provided to all staff and frequent hand hygiene and mask wearing audits were undertaken. Cleaning hours had been increased daily and cleaning procedures were updated and frequency increased for specific areas of the centre. Training was ongoing and the centers housekeeping staff were seen to be competent in decontamination cleaning and general infection control measures.

Protocols were in place for symptom monitoring and health checks for residents, staff and visitors to the centre. Staff wore appropriate PPE and hand sanitisers were appropriately located along corridors.

Residents who returned from hospital and newly admitted residents were kept in 14 days isolation. PPE stations were appropriately set out along the corridors in close proximity to residents bedrooms and clinical waste was effectively managed.

Judgment: Compliant

## Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. There are a number of areas of serious concern regarding the adequacy of fire safety precautions in the centre. The provider was requested to make urgent contact with their fire safety consultants and to provide a date by when the required works would commence and a time frame for completion of these works.

The registered provider was not taking adequate precautions against the risk of fire:

- The workshop/store was found to present a risk to the safety of residents. Numerous oxygen cylinders were seen in the centre which were not stored in line with the centre's own risk assessment for oxygen storage. Most oxygen cylinders were located in the workshop/store, which included a significant number of combustible materials and a charging station for hoist batteries. Inspectors were of the view that there was not a sufficient number of fire detectors. This posed a high risk of fire and required immediate review and action.
- The arrangements for the storage and use of oxygen requires review. One of the oxygen cylinders referred to above was found loose within a store inside a resident's bedroom. This had not been identified by staff.

Inspectors were not assured that adequate means of escape was provided throughout the centre:

- Two bedrooms were inner rooms, with escape through the day room/conservatory space. This meant that inner rooms were being used as bedrooms. In a building of this type and occupancy, inner rooms are not permitted to be used as bedrooms as the residents are not afforded adequate means of escape.
- The ceiling over the conservatory was not constructed with materials that would adequately prevent the spread of fire.
- There was a chair lift located on an escape stairs reducing the effective width of the stairs and the escape route at the foot of the stairs.
- A bedroom corridor was noted to have a medication trolley, laundry bins, a

rubbish bin and a fridge locked within a cabinet.

Adequate arrangements were not in place for maintaining all fire equipment and means of escape:

- Due to the observed deficiencies to fire doors in the centre, improvements were required to the in house fire safety checks to ensure they are of adequate extent, frequency and detail.
- A chair was noted on the landing of the external stairs creating an obstruction.

The provider did not have adequate arrangements to review fire precautions:

- Considering the findings of the fire safety report issued issued by the fire consultant in October 2020, the registered provider had failed to implement the recommendations of that report.

Adequate arrangements had not been made for detecting fires:

- A number of areas did not have adequate detection of fire. For example, the reception area, small stores and the small laundry room. There were other areas where detection was provided but was not sufficient given the size and varying roof heights of the spaces.

Inspectors were not assured that adequate arrangements were in place for containing fires:

- A number of attic access hatches and services were mounted in the floor/ceilings, creating potential breaches to the fire resistance of the floor/ceiling.
- The inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery). The inspectors noted a number of fire doors which did not close effectively. For example, a fire doors to a bedroom did not fully close when checked by the inspectors. This door had also been identified on the previous inspection and the provider provided assurances at that time, that it had been addressed. This door was altered during the inspection to facilitate closure. Other doors were also noted not to close fully and it was evident that there was no ongoing system in place for the regular checking of fire doors. Assurances were required that all doors would close effectively which needed to be implemented with immediate effect and confirmation sent to the Chief Inspector.
- The enclosure to the boiler room was not adequate. The inspectors noted a penetration through the wall for wiring to an adjacent bedroom. The inspectors issued an immediate action for a carbon monoxide detector to be fitted in the resident's bedroom and the breach in the fire rated construction to the boiler room to be sealed up.A sluice room was not fitted with a fire door.
- Inspectors noted a number of gaps or holes within fire barriers which require sealing to ensure smoke and fire do not spread through the fire barrier.

- The kitchen was not adequately separated from the adjoining bedroom area.

The person in charge did not ensure that procedures to be followed in the event of a fire were adequately displayed:

- Inspectors noted additional exit signage was required from some areas of the centre to ensure escape routes are readily apparent.
- Zoning floor plans were not displayed next to the fire alarm panel.

Judgment: Not compliant

## Regulation 29: Medicines and pharmaceutical services

Comprehensive systems were seen to be in place for medicine management in the centre. Competency assessments were undertaken on all nurses administration practices, by the person in charge. Medicine management was audited frequently and staff had undertaken training. The pharmacist was supportive in these audits. Out of date medicines and medicines which were no longer is use were returned to pharmacy. Controlled drugs were carefully managed in accordance with professional guidance for nurses. All staff signed when medicines had been administered and medicines which had been discontinued were signed as such by the general practitioner (GP)

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Care planning documentation was available for each resident in the centre. A pre-admission assessment was completed prior to admission to to ensure the centre could meet the residents' needs. All care plans reviewed were personalised and updated regularly and contained detailed information specific to the individual needs of the residents and were sufficiently detailed to direct care. Comprehensive assessments were completed using validated tools and these were used to inform the care plans. There was evidence of ongoing discussion and consultation with the families in relation to care plans. Care plans were maintained under regular review and updated as required.

Judgment: Compliant

## Regulation 6: Health care

The inspectors were satisfied that the health care needs of residents were well met and that staff supported residents to maintain their independence where possible. There was evidence of good access to medical staff with regular medical reviews in residents files. During the COVID-19 pandemic the regular GP practices continued to provide a service to the residents. In relation to COVID-19, there was evidence of liaison with the public health officer and with the HSE locally regarding supplies of PPE, testing vaccinations and management of same.

Residents had access to a range of allied health professionals which had continues throughout the pandemic with some reviews taking place online. Residents' weights were closely monitored and appropriate interventions were in place to ensure residents' nutrition and hydration needs were met. Residents had been reviewed by the dietetic services and prescribed interventions which were seen to be appropriately implemented by staff. Wounds were well-managed with the support of specialist advice and dietetic input. Residents in the centre also had access to psychiatry of older life and attendance at outpatient services was facilitated as required.

Judgment: Compliant

## Regulation 9: Residents' rights

There was evidence that residents were consulted with and participated in the organisation of the centre and this was confirmed by residents. Overall, residents' right to privacy and dignity were respected and positive respectful interactions were seen between staff and residents.The residents had access to individual copies of local newspapers, radios, telephones and television. Advocacy services were available to residents as required.

The requirement to maintain a social distance impacted on social activities in the centre. Although larger group activities and gatherings were discontinued due to COVID-19, there was an ongoing programme of smaller group and one-to-one recreational activities for residents to partake in. These were carried out in accordance with public health advice and inspectors observed that there was space to facilitate social distancing. A social assessment had been completed for residents which gave an insight into each resident's history, hobbies and preferences to inform individual activation plans for residents.

Judgment: 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 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management | Substantially compliant |
| Regulation 27: Infection control | Compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and care plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Willowbrook Lodge OSV-0000302

## Inspection ID: MON-0030526

## Date of inspection: 24/02/2021

**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 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>All fire safety issues still outstanding are being addressed by Surespec Fire Ltd with the guidance of Michael Slattery & Associates. We are also liaising with John Hoctor in Tipperary County Council who is advising us.<br><br>More robust Management Systems will be put in place to address risks that may arise in future in the premises. We are actively seeking to improve our Governance and Management by employing someone with the requisite experience and expertise to ensure these matters never arise again. | |
| Regulation 17: Premises | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>We have removed all clutter from the storage areas, bathrooms and corridors. All equipment is now stored in appropriate areas. We purchased extra storage sheds to assist with this.<br><br>We have provided more wardrobe space in rooms where it was deemed to be inadequate. | |

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| Regulation 26: Risk management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management:
We will regularly review our Risk Management Policy to ensure all risks have been assessed and included.

The loose wires witnessed by the inspector have been tidied up and secured and no longer pose a risk.

The stair lift has been removed entirely from the building.

The window blind cords have been secured and no longer pose a risk to residents.

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| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
We have taken a number of interim measures to improve the fire safety of the building while we await approval from the Council for our proposed Schedule of Works. Please see attached document outlining same.

The workshop/store has been cleared of all combustible material. All oxygen cylinders have been removed and are stored away from the building in a suitable cage/container. The charging unit for hoist batteries has been relocated. A number of additional detectors have been installed in this area.
The use of oxygen cylinders is strictly monitored and all cylinders are kept in the above mentioned cage when not in use.
It is proposed to remove the thermoplastic roof from the conservatory, and sub-divide the structure to provide a protected escape route for bedrooms 14 & 15. This action will fully meet the requirements of the 2001 FSC.
The chairlift has been removed.
We have reduced clutter as much as possible in this corridor and found more suitable areas for some of these items.

We have a staff member check all fire doors weekly. He is in the process of replacing any door furniture which is not up to standard.
We have at least 5 Fire Wardens on site at all times during the daytime and 2 at night.
We have employed an extra staff member at night to allow a Fire Warden patrol the premises at hourly intervals ready to respond to any fire emergencies. Please see attached checklist for their patrol.
All obstacles have been removed from the external stairs.

We have engaged qualified and accredited fire experts and consultants to assist in

improving the fire safety of the building. We are also liaising with the local County Council Fire Department.

We have installed extra fire detection devices as per the attached document. The alarm system will be brought up to full L1 standard.

All breaches in the floor/ceilings will be fully fire proofed.
All fire doors now close correctly. We are in the process of replacing all door furniture that does not come up to the requisite standards. All fire doors are regularly checked once a week now. We are assessing which doors need replacing and/or upgrading.
The issues with the boiler room have been addressed. The penetration through the wall has been sealed and a carbon monoxide alarm was installed in the resident's bedroom.
We will fit a fire door to the sluice room.
The gaps and holes in the fire barriers will be sealed .
The kitchen will be separated from the adjoining bedroom area.

Our fire experts have assured us that our exit signage is now sufficient.
Floor plans are now displayed next to the fire alarm panel.

## 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 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 | 26/04/2021 |
| 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 | Orange | 30/09/2021 |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, | Not Compliant | Orange | 30/05/2021 |

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| | consistent and effectively monitored. | | | |
| Regulation 26(1)(a) | The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre. | Substantially Compliant | Yellow | 26/04/2021 |
| Regulation 28(1)(a) | The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings. | Not Compliant | Red | 26/02/2021 |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 30/09/2021 |
| 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 | 26/02/2021 |
| Regulation 28(1)(c)(ii) | The registered provider shall make adequate arrangements for reviewing fire | Not Compliant | Red | 26/02/2021 |

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| | precautions. | | | |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Red | 26/02/2021 |
| Regulation 28(3) | The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre. | Substantially Compliant | Yellow | 26/04/2021 |