Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Lucan Lodge Nursing Home
Centre ID:	0061
Centre address:	Ardeevin Drive Lucan, Co. Dublin
Telephone number:	01 6280555
Fax number:	01 6280745
Email address:	Julie@lucanlodge.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Lucan lodge Nursing Home
Person in charge:	Julie Fuller
Date of inspection:	11 October 2011
Time inspection took place:	**Start:** 09:00 hrs **Completion:** 18:00 hrs
Lead inspector:	Linda Moore
Support inspector:	Angela Ring
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Lucan Lodge Nursing Home is a four-story residential centre with 72 places. On the day of inspection there were 69 residents living there. The residents reside on three floors - Level 1 is the basement, Level 2 is the ground floor and Level 3 is the first floor.

Level 1 can accommodate 15 residents and is the Alzheimer's Unit. This unit consists of an open plan dining/sitting room, a small kitchenette and an additional sitting room. There are five single rooms with en suite sink and toilet, as well as ten single rooms and two assisted shower rooms/bathrooms. The main kitchen is also on this level.

Twenty one residents reside on Level 2 which has 21 single rooms, 11 of which have en suite sink and toilet. There are three assisted toilets/shower rooms on this level as well as a large dining room/sitting room and additional seating on the corridor. There is a second smaller sitting room, oratory and a hairdressing room.

Thirty six residents reside on Level 3 which consists of thirty single rooms, 10 of which have en suite sink and toilet. There is also one twin room and one four-bedded room. There are three assisted toilets/shower rooms and one assisted toilet with a Jacuzzi bath. There is a small seated area on this floor and some residents dine here.

Location

Lucan Lodge Nursing Home is located in a residential housing estate close to Lucan Village within a short distance to restaurants, a bank, public houses, libraries and shops

Date centre was first established:	17 April 1987
Number of residents on the date of inspection:	69 + 1 in hospital
Number of vacancies on the date of inspection:	2

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	26	16	19	9

Management structure

The Provider is Lucan Lodge Nursing Home and Tanya Patterson a company director who works full-time in the centre is the person named to act on behalf of the Provider. Julie Fuller is the Person in Charge. Simi Chacko is the Clinical Nurse Manager Level Two (CNM2) and there are also three Clinical Nurse Managers Level One (CNM1). There are eleven staff nurses, seven care assistant supervisors and 35 care assistants. There are three cleaning supervisors, six housekeeping staff, three chefs and four catering assistants, one laundry supervisor, two laundry assistants, one activity supervisor and one exercise coordinator. The care assistants report to the care assistant supervisors who in turn report to the nurses. The nurses report to the CNM1 who reports to the CNM2. The CNMs report to the Person in Charge who in turn reports to the Provider. Each non-clinical grade of staff reports to a supervisor who in turn reports to the person in charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	5*	14	3	8	1	1**

* One CNM2 and One CNM1
** Provider and two activity staff

Background

Lucan Lodge Nursing Home was inspected for the purpose of registration Inspection carried out by the Health Information and Quality Authority (the Authority) on the 20 and 21 June 2011. Inspectors found that most of the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 were met.

They had established strong management processes to ensure the delivery of services to residents in a consistent and safe manner. The provider and person in charge were extremely committed to providing ongoing training to staff and to family members. Residents' healthcare needs were catered for and they had access to peripatetic services.

The premises were comfortable and well maintained. Inspectors found that staff were committed to caring for residents and meeting their needs. The centre was described as a home from home and staff aimed to provide this.

However, inspectors had concerns about the management of behaviours that challenge, as the systems in place to protect residents from being harmed were not effective. Inspectors were also concerned about the management of residents who required restraint. The person in charge was required to address these areas of concern as a priority.

The previous action plan identified areas where improvements were required to comply with the requirements of the Regulations and *the National Quality Standards for Residential Care Settings for Older People in Ireland,* such as:

- the statement of purpose did not fully reflect the service provided in the centre and did not meet all of the requirements in Schedule 1 of the Regulations
- the provider and person in charge did not take appropriate action when a resident was harmed
- the risk management policy did not meet the Regulations or guide practice
- the emergency plan did not include the transportation arrangements from the centre to the emergency site identified
- the practice regarding recording and disposal of medication required improvement
- the significant improvements required in the development of care plans
- restraint practice was not based on evidenced based best practice, and there was no evidence that alternatives had been considered
- residents who had a fallen did not have a falls reassessment completed and their care plans were not updated to reflect their changing needs
- all residents with cognitive impairment did not have opportunities to participate in activities appropriate to his or her interests and capacities
- each resident who required a specialised diet was not provided with choice at meal times
- there was inadequate staffing levels to assist residents at meal times
- suitable chairs with foot supports were not provided to residents
- the policy for behaviours that challenge was not implemented

- many residents who were highly dependent and with cognitive impairment remained in bed every day or only got up on alternate days
- notifications of incidents were not submitted to the Authority in accordance with the requirements set down in the Regulations.

This additional inspection report outlines the findings of a follow up inspection that took place on 11 October 2011. The inspection was unannounced and focused on the actions of the inspection of 20 and 21 June. The inspectors met the provider, person in charge, clinical nurse managers and a number of staff, residents and relatives.

Summary of findings from this inspection

This was an unannounced follow up inspection and the centre's third inspection. It focused on areas identified for improvement at the registration inspection carried out on 20 and 21 June 2011.

Inspectors found that the provider had been proactive in responding to the action plan from the previous inspection. Twelve of the fifteen actions identified had been fully completed and significant progress had been made with the remaining three actions. Some of the outstanding items were still within the timeframe agreed in the previous inspection report and the provider stated that they would be completed within this timeframe.

Improvements made by the provider since the previous inspection included:

- the statement of purpose had been updated to reflect the services and facilities provided for residents and now met the Regulations
- significant progress regarding the development of the risk management policy, emergency plan and medication management policies
- appropriate staffing and skill mix was in place
- residents had care plans that addressed their assessed needs, the services of an occupational therapist had been provided, and residents' quality of life had improved with appropriate seating, activity provision and menu choices.

Improvements were still required in the management of behaviors that challenge and of restraint. Areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Actions reviewed on inspection:

1. Action required from previous inspection:

Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

This action was completed.

The statement of purpose had been amended to meet with the requirements of the Regulations and a copy was forwarded to the Authority and available to residents. It reflected the services and facilities provided.

2. Action required from previous inspection:

Further develop and maintain a system for improving the quality and safety of care provided at Lucan Lodge.

The action was completed.

The staff nurses continued to collect monitoring data which was discussed by management at the weekly audit meeting. The audit form to capture and review data on care issues was revised and now provided more accurate information on the service. The person in charge and nurse managers met each week and used the audits to review and improve the service. The information included falls, resident who had lost weight, residents with wounds and any significant events. The managers provided guidance to the staff following their meeting and they recorded the future plan for the resident. Inspectors read where the information was used to review the service and plan the week ahead.

A number of audits were ongoing, there was an audit of behaviours that challenge, and of admission, transfer and discharge audit completed since the previous inspection. The clinical nurse manager identified the need to review the audit template to gather information which was meaningful and could be used to improve the service. The person in charge and clinical nurse manager were working to the timeframe for completion of this action by end of October 2011 as agreed in the previous inspection report.

3. Action required from previous inspection:

Take appropriate action where a resident is harmed.

This action was completed.

There were systems in place to protect residents being harmed. Inspectors read the risk assessments carried out on all residents in the dementia unit who may be at risk from other residents and they noted that the control measures identified were included in these residents' care plans. Three residents at risk were reviewed by the Psychiatry of Later Life team. An adverse incident investigation was undertaken after incidents had occurred and action plans were implemented to minimise the risk of a reoccurrence. See Action 9 regarding behaviours that challenge.

4. Action required from previous inspection:

Provide handrails on both sides of stair cases.

This action was completed.

Handrails were fitted to the stairwell and inspectors observed a magnetic lock to the door at the bottom of the stairs.

5. Action required from previous inspection:

Revise the risk management policy to include all aspects of the identification and assessments of risks, throughout the designated centre and the recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

This action was completed.

The risk management policy which was read by inspectors had been updated and now included precautions to control specific risks such as the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

The policy also included the identification and assessments of risks, throughout the designated centre and the recording, investigation and learning from serious or untoward incidents or adverse events involving residents. The policy was implemented in practice as all clinical and non clinical risks were discussed at the weekly audit meeting and appropriate action taken.

6. Action required from previous inspection:

Revise the emergency plan for responding to emergencies.

This action was completed.

The Emergency Plan was revised and it was now more specific to guide practice in the event of an evacuation. Staff were knowledgeable of this plan.

7. Action required from previous inspection:

Put in place appropriate and suitable practices and written operational policies relating to the prescribing, and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

This action was completed.

The medication management polices which were read by inspectors had been revised since the previous inspection and now met best practice guidelines. It now guided practice and staff were aware of these.

8. Action required from previous inspection:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

This action was partly completed and improvements were in progress towards achievement of the action within the agreed timeframe.

Inspectors observed that the person in charge and clinical nurse manager had begun to audit the care plans. Guidance was provided to all staff nurses in the development of care plans. Training on care planning was planned for end of October 2011 for five staff nurses. The care plans were under review at the time of inspection and there had been considerable progress in this area since the previous inspection. They were in the process of being changed in consultation with residents, staff and their families. The person in charge and clinical nurse manager were aware of the deficits in this area in that all care plans did not meet the standard set by the person in charge and they were working to the timeframe for completion of this action by end of October 2011 as agreed in the previous inspection report.

9. Action required from previous inspection:

Provide all care in accordance with evidenced based best practice.

This action was partly completed. The provider said the action was completed.

Falls Management

There was some improvement in the management of falls in line with the falls policy. However, the policy did not always guide practice. A new comprehensive post falls assessment was developed, but the inspectors found that this assessment was not

consistently undertaken following a fall. All residents at risk of falling had been reviewed by the physiotherapist. The person in charge had not had the opportunity to implement all areas for improvement as identified in the previous falls audit such as the introduction of a falls prevention nurse.

Residents Remaining in Bed

There had been considerable improvement noted. Residents who had previously remained in bed due to routine practice were facilitated to get up during the day. There was only one resident who chose to remain in bed and the reason for this was documented. This resident was checked every thirty minutes while in bed.

Restraint

A comprehensive policy on the management of restraint was in place. There was some good practice noted in the area of restraint but improvements were required in line with the policy. A new assessment for restraint was implemented and in most regards this included the relative or resident involvement and the alternatives tried. The number of bedrails had been reduced and residents said they were happy with this. Some residents with bedrails had a comprehensive care plan to detail the care to be provided. All residents requiring bedrails were checked every hour over night. However, this good practice had not been rolled out throughout the centre. One resident's record showed that no alternatives had been tried and bedrails were used in the absence of appropriate staff and supervision. This contravened the policy which stated that "restraint use is not permitted as a substitute for correct staffing levels and competence".

Behaviours that Challenge

There was a comprehensive policy on the management of behaviours that challenge which in many regards guided the care delivered. There had been some improvement in this area since the previous inspection. However, it continued to be an area that required considerable input from management. Inspectors reviewed the incident reports and noted that there had been two incidents of behaviours that challenged where one resident had been assaulted by another resident with a cognitive impairment in the past four months. Inspectors reviewed files and noted that residents with behaviours that challenge had an assessment for their behaviour completed using a recognised assessment tool. There continued to be a lack of awareness by staff of the use of this tool. Residents had a care plan for dementia which included the triggers for the behaviour, the behaviour itself and the interventions to be tried to reduce the behaviour. All staff had attended training on crises prevention intervention. An additional staff member was allocated to the dementia unit to assist at tea time and alleviate some of the behaviours that occurred at meal times. While the care was person-centred and in most regards met residents' needs, there was a lack of expertise in the dementia unit in the management of behaviours and some resident's behaviours continued to pose a risk to other residents. Therefore, inspectors remained concerns about the management of these residents on a consistent basis.

10. Action required from previous inspection:

Provide suitable equipment as may be required for residents.

This action was completed.

An occupational therapist (OT) was employed on a part-time basis every week since the previous inspection. Seating assessments were completed for all residents at risk, the report of which was read by the inspectors. New equipment was purchased for one resident to enable her to sit out for two hours in her chair each day. The GP had referred residents who required additional seating support to a specialist in that area. The referrals were viewed by inspectors.

11. Action required from previous inspection:

Provided opportunities for all residents to participate in activities appropriate to his or her interests and capacities.

Work was ongoing in this area.

Most residents were provided with opportunities to participate in activities appropriate to his or her interests and capacities. Inspectors saw how care staff had been allocated to provide activities for residents with a cognitive impairment - this was in addition to the two activities staff. The activities provided included aromatherapy and hand massage. The records were viewed on the computerised system. The occupational therapist had reviewed all residents with a cognitive impairment in relation to their fulfilment needs and had developed a plan for each resident. The person in charge said the activity person and occupational therapist were planning to work together to implement the plans.

12. Action required from previous inspection:

Provide each resident with food that is varied and offers choice at each mealtime.

This action was completed.

The menu had been revised. Residents who required specialised diets were now provided with a choice of meal. The menus on the tables displayed the choice offered. Inspectors observed residents being offered the choice and relatives said they were satisfied with the choice of meal offered.

13. Action required from previous inspection:

Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

This action was completed.

Inspectors observed good levels of supervision of residents at meal times. The person in charge told inspectors that she had reviewed the supervision of residents who were highly dependent with the management team and appropriate measures had been put in place to ensure clinical supervision to meet residents' health and social care needs. The person in charge said that the numbers of care assistants had been increased since the previous inspection - this was viewed in the rota. She said that staff were also deployed more efficiently in that there was a clinical nurse manager and two nurses in the dining room at meal times and additional carers were brought from level three to assist residents. Inspectors observed that this was the case and noted that there was appropriate staff available to assist residents with their meals.

14. Action required from previous inspection:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

This action was partly completed.

A number of pictorial signs were erected in the dementia unit and some residents told inspectors the purpose of these signs. The provider was continuing to review the window in the sitting room in the dementia unit area as it faced a wall and she was working to the timeframe for completion of this action by end of December 2011 as agreed in the previous inspection report.

15. Action required from previous inspection:

Provide a written report to the Chief Inspector at the end of each quarter of the occurrence in the designated centre of any accident.

This action was completed.

Inspectors found that all notifications including quarterly notifications had been reported to the Chief Inspector in a timely manner.

Report compiled by:

Linda Moore

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

12 October 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
21 October 2009	☐ Registration ☒ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
20 and 21 June 2011	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report *

Centre:	Lucan Lodge Nursing Home
Centre ID:	0061
Date of inspection:	11 October 2011
Date of response:	25 October 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider is failing to comply with a regulatory requirement in the following respect: A high standard of evidenced based best practice was not consistently provided in relation to behaviours that challenge and restraint.	
Action required: Provide all care in accordance with evidenced based best practice.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

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

Provider's response: Falls - A falls nurse had been appointed but requires more education, and we now have two nurses appointed and another falls audit is taking place. Restraint - We will in future ensure that restraint practice is guided by policy and to this end will re-educate all nurses about our policy. We have required all our nurses to re-read restraint policy and they will have a competency assessment on same. All residents will have assessment and all alternatives stated in our policy will be tried before cot sides are used. A consistent approach to this policy will be rolled out for all our residents and all care plans will be reviewed. Challenging behaviour - We are looking at reviewing the management of this unit and appointing a specific nurse to ensure consistency of approach. Provider has begun Dementia Care Mapping and is also undertaking a course regarding Dementia Design in November. Care staff and nurses have received education regarding dementia and behaviours that challenge and have received crisis prevention education. However, we will provide further education to all staff to ensure that policy guides practice. Nursing staff have undertaken further education on assessment and care planning and a competency of their knowledge will take place.	End December 2011 End December 2011 End December 2011

2. The provider is failing to comply with a regulatory requirement in the following respect: The physical design and layout of sitting room in the dementia unit may not meet the needs of each resident.	
Action required: Continue with plans to ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: In my original response in June last I gave the end of December as the timeframe, this has not changed. I am going to undertake a course in Dementia Design in November and will review environment on return.	December 2011

Any comments the provider may wish to make:

Provider's response:

None

Provider's name: Tanya Patterson
Date: 25 October 2011