Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Lucan Lodge Nursing Home
Centre ID:	0061
Centre address:	Ardeevin Drive Lucan Co. Dublin
Telephone number:	01 6280555
Email address:	Julie@lucanlodge.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Lucan Lodge Nursing Home
Person authorised to act on behalf of the provider:	Tanya Patterson
Person in charge:	Julie Fuller
Date of inspection:	13 and 14 August 2012
Time inspection took place:	**Day-1 Start:** 10:30 hrs **Completion:** 17:30 hrs **Day-2 Start:** 08:30 hrs **Completion:** 15:30 hrs
Lead inspector:	Deirdre Byrne
Support inspector:	Finbarr Colfer
Type of inspection	☐ **announced** ☒ **unannounced**
Date of last inspection:	11 October 2011

About inspection

The purpose of inspection is to gather evidence on which to make judgements 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* under 18 outcome statements. The outcomes set out what is expected in designated centres.

Outcome 1 *There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.*
Outcome 2 *The quality of care and experience of the residents are monitored and developed on an ongoing basis.*
Outcome 3 *The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure*
Outcome 4 *Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.*
Outcome 5 *The health and safety of residents, visitors and staff is promoted and protected.*
Outcome 6 *Each resident is protected by the designated centre's policies and procedures for medication management.*
Outcome 7 *Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*
Outcome 8 *Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*
Outcome 9 *Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.*
Outcome 10 *Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

Outcome 11 *Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*
Outcome 12 *Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*
Outcome 13 *The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*
Outcome 14 *There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*
Outcome 15 *The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*
Outcome 16 *The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).*
Outcome 17 *A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*
Outcome 18 *The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

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

The inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Lucan Lodge Nursing Home is located in a residential housing estate close to Lucan Village within a short distance of restaurants, banks, public houses, a library and shops.

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

Level 1 is a dementia care unit with 15 beds. 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 wash-hand basin and toilet and 10 single rooms with wash-hand basin only. There are two assisted shower rooms/bathrooms. The main kitchen is also on this level.

Level 2 has 21 residents. There are 21 single rooms, 11 of which have en suite wash-hand basin 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, an oratory and a hairdressing room.

Level 3 has 36 residents. There are 30 single rooms, 10 of which have en suite wash-hand basin and toilet, one twin room and one four-bedded room. There are three assisted toilets/shower rooms and one assisted toilet/Jacuzzi bath. There is a small sitting room area on this floor and some residents dine here.

Date centre was first established:	17 April 1987
Date of registration:	13 December 2011
Number of registered places:	72
Number of residents on the date of inspection:	69

Dependency level of current residents as provided by the centre:	**Max**	**High**	**Medium**	**Low**
Number of residents	19	23	11	16

Gender of residents	**Male (✓)**	**Female (✓)**
	✓	✓

Management structure

The Provider is Lucan Lodge Nursing Home Limited and Tanya Patterson, one of the Directors, is the person named to act on behalf of the company and works full-time at the centre.

Julie Fuller is the Person in Charge. There is one Clinical Nurse Manager Level Two (CNM2) and two Clinical Nurse Managers Level One (CNM1). 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. The physiotherapist, occupational therapist and activities coordinators report to the person in charge. There are supervisors for housekeeping, laundry and kitchen staff and these also report 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*	13	3	6**	2***	6****

* including one CNM2 who is supernumery to the nursing staff
** two laundry and four household staff
*** Accountant and receptionist
**** three activities coordinators, Physiotherapist, Occupational Therapist and Aroma therapist

Summary of compliance with 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*.

This report set out the findings of an unannounced inspection. This inspection took place over two days. As part of the inspection, inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Whist there was a need for improvements in some areas to achieve full compliance with the Regulations. Inspectors found the centre was well run through the management of the provider and the person in charge. There was good nursing practice observed, with residents' social and medical care needs looked after. Residents had access to their own or the centre's general practitioner (GP) and a range of allied health services. There was a range of activities and outings from the centre available to residents. The centre had a lively atmosphere with residents moving about and its many visitors coming and going throughout the day.

There were procedures in place to ensure that residents received care in a dignified and respectful manner. There were systems in place to safeguard residents from abuse. The centre was in a clean condition and was a warm, comfortable and homely premises maintained to a good standard. Staff were observed treating residents in a kind and patient manner. Staff were provided with training and were participating in further education to enhance their roles in care delivery.

The previous inspection report identified two areas of non compliance that the provider was required to address. Inspectors found that the first of these was fully addressed and there were plans in place to address the second:

1. A high standard of evidenced based best practice was seen to be provided in relation to behaviours that challenge and restraint management.
2. Visibility and natural light from a window in the sitting room and from a bedroom on Level 1 were obstructed by a wall outside these rooms.

On this inspection, inspectors identified a number of other areas that required improvements to ensure compliance with the Regulations and these included:

- the contract of care did not contain all of the mandatory information required by the Regulations
- some policies reviewed did not reflect or guide the work practices in the centre
- there was inconsistent recording of checks of fire exits and automatic door releases
- risk was not managed fully in some areas such as brakes applied to trolleys and use of foot plates when mobilising residents on wheelchairs.

These are discussed in the body of the report and included in the Action Plan at the end of this report.

Compliance with 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. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

Inspectors found substantial compliance in relation to this outcome. A written statement of purpose was in place and it accurately described the layout of the centre and the services provided to residents, along with the type of care and manner in which it was to be delivered.

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

Overall there was substantial compliance in relation to this outcome. Inspectors found there was evidence of robust systems in place to monitor and improve the quality of care and quality of life of residents in the centre on an ongoing basis.

There was a weekly collection of data from each of the three levels in the centre of key performance indicators such as restraint, falls and behaviours that challenged. Nurses and the CNM2 told inspectors that meetings to discuss the information gathered had been increased from monthly to weekly and were being used to monitor and respond to any issues that arose.

A programme of auditing was in place to monitor the quality of care and the safety of residents in the centre. There were regular audits of such areas as falls, wounds, elder abuse, medication management and restraint. Each audit was given a percentage compliance rate to reflect the centre's compliance with the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

A sample number of these audits were reviewed by inspectors including one on use of restraint. Where issues had arisen, immediate action was seen to be taken and improvement made as a result. For example, certain pertinent information such as a record of alternatives to restraint that had been tried was not being gathered in the assessments of residents for the use of bedrails. As a result, a new bedrail assessment form was developed and implemented. Inspectors also read an audit of pressure sore records completed in November 2011. Issues identified included some residents not having an up-to-date wound assessments completed and the need to involve families more in care plans. Inspectors found that the provider had taken action in response to this. Staff were informed of the outcome and were reminded of the requirement to keep assessments up to date using the standardised assessment tool which included a record of consultation with the residents or families.

Two residents' committee meetings were held in the centre every three months, one for residents on the ground floor and another for those on the first and second floors. These meetings gathered feedback from residents and relatives and the information was used to identify ways of improving the quality of life of residents in the centre. Minutes of a recent meeting with residents on the first and second floor was seen by inspectors, a number of issues had been raised by the residents including one regarding the sitting room on the first floor being too warm. Inspectors saw there was an action to install fixed fans in the sitting room and that those fans had been recently installed in the room as planned.

There were three annual satisfaction surveys distributed for feedback from residents and relatives. The results of a number of these surveys were reviewed by inspectors who found that action had been taken to address the issues raised. For example, one issue was in relation to noise levels at night disturbing a resident. A sign reminding passersby to be quiet at night was provided on the resident's door and at the nurses' station. These signs were seen by the inspector.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings
Inspectors found there was an effective complaints system in place, with complaints being well managed and responded to in a timely manner and there was an appeals procedure if residents were unsatisfied with the outcome.

Inspectors viewed the complaints policy for the centre and the detailed complaint procedure which was on display at entrance reception area and on each of the Levels. Complaints could be made verbally or in writing and complaints forms were available at the entrance beside the procedures. Verbal and written complaints were all logged on the centre's computerised system with additional documentation in

hard copy when a full investigation was required. Complaints were investigated with the outcome reported back to the resident or resident's family. Inspectors found evidence that the provider kept the complainants or their representatives informed throughout the process. Where the complainant continued to have issues, arrangements were put in place to meet regularly with the complainant and with family members where appropriate.

Residents told inspectors that if they had a complaint they would speak to the member of staff who facilitated the residents' meetings or to the person in charge. Staff told inspectors they would always try to resolve complaints at a local level first but if a resident was unhappy they would bring it to the nurse in charge and make a written submission. Staff recorded verbal complaints on the residents' file on the computerised system.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings

There were good safeguarding measures in place to protect residents from being harmed or suffering abuse. Policies and procedures had been drawn up to guide staff in the prevention, detection and response to abuse. Staff had received training in how to identify and respond to abuse and those spoken to were knowledgeable of the types of abuse and how they would respond to a suspicion or an allegation of abuse. Residents also told inspectors that they felt safe in the centre and that the staff were very kind to them.

However, inspectors found improvements were needed in the management of residents' personal finances. Day to day money deposited by residents in the centre was managed by the person in charge. Lodgements and withdrawals of cash were recorded on the centre's computerised system. Inspectors found that one of the accounts had a discrepancy in the cash total and the computer total. In addition, lodgements and withdrawals were not being signed and dated consistently to ensure robust accountability.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings
Inspectors found that risk to the health and safety of residents, staff and visitors was being adequately managed in the centre and that practices were in place to promote and protect the safety of individuals. However, improvements were needed in some areas to manage risk more effectively.

A risk management policy was in place and contained the information required by the Regulations. The safety statement had been reviewed in June 2012 by external health and safety consultants. The report was reviewed by inspectors and it included recommendations for improvements which the provider was in the process of implementing. The statement included a risk assessment section on areas such as work practices, the environment and the use of equipment. Risks were identified, assessed and control measures put in place. There were measures to control risk to food safety, with a food safety system based on HACCP (Hazard Analysis Critical Control Points) in place. However, inspectors identified a number of risks that had not been included in the risk assessments including the absence of brakes on a drinks trolley on a corridor which could be a falls risk for residents and a number of wheelchairs used to transfer residents did not have foot plates applied.

There were suitable infection control measures in both cleaning and laundry. Inspectors reviewed the infection control policy and found it provided clear guidelines to staff. Inspectors spoke to staff and they were knowledgeable of infection control measures and the policy. Staff were observed using appropriate personal protective equipment (PPE) in the course of their work. PPE such as plastic aprons, gloves and hand gels were in plentiful supply throughout the centre. The centre and its surroundings were maintained to a suitable standard and kept in a clean condition.

A health and safety committee met regularly, with the last meeting held in May 2012. Minutes of these meetings were reviewed by inspectors and they included the outstanding matters from the previous meeting and discussion of the outcome of monthly health and safety audits.

There were robust systems in place to manage the risk of injury through accidents, and all incidents were being documented. Inspectors reviewed the accident/incident records and found that they included a detailed account of the incident, the response taken, the monitoring carried out and whether the family and GP were informed. Falls in the centre were managed well. All residents were assessed for being at risk of fall and were re assessed if they had a fall to inform measures to prevent the

recurrence of the fall. The provider was undertaking regular falls audits and inspectors reviewed the results of the March 2012 audit. Actions taken as a result of the audit included the involvement of the physiotherapist and occupational therapist in assessing residents following a fall and the introduction of a new environmental and falls risk assessment.

Training in movement and handling for staff was up to date. Inspectors saw staff using good practice when assisting residents to mobilise.

An emergency plan was in place and it described a broad range of emergencies and the appropriate immediate responses. It included procedures to guide staff including details of alternative accommodation and the transport arrangements if full evacuation of the centre was needed.

Suitable precautions were in place to prevent fire and protect residents. Fire evacuation procedures were displayed throughout the centre to guide staff, residents and visitors.

Fire safety and evacuation training had been carried out for all staff on an annual basis and staff were knowledgeable of fire evacuation procedures. Fire drill practices were carried out every six months and a record of each drill was kept which included staff and instructor names. However, the outcome of the fire drill was not being recorded to inform staff learning to improve fire responses.

There were documented inspections and maintenance of fire fighting equipment and fire alarms on an annual and quarterly basis respectively carried out by external contractors. However, inspectors found that daily checks of fire exits were not being recorded consistently with gaps of a number of days between checks. A monthly check for automatic door releases had not been recorded since May 2012.

Outcome 6
Each resident is protected by the designated centre's policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings
Inspectors found that residents were protected by the centre's policies and procedures for medication management. Policies were in place on the ordering, prescribing, storing and administration of medicines. Robust accountability systems were in place.

Nurses had received medication management training in February 2012. Inspectors discussed the management of medication with nursing staff and found they were knowledgeable and aware of the centre's procedures and the current professional guidance from An Bord Altranais.

Centre-specific procedures were in place for the handling of controlled drugs and these were stored in a locked cupboard in the nurses' station. There was a register maintained that kept a record of all such drugs in the centre, as per the Misuse of Drugs (Safe Custody) Regulations, 1984. Each drug was checked, dated and signed twice daily by two nurses. Inspectors viewed the register and counted a sample of drugs and found that balances were correct and accounted for.

There were three monthly reviews of residents' medications carried out by the GP and by the psychiatric team where required. These were done along with the person in charge. The pharmacist carried out monthly audits including a review of medication administration sheets.

Inspectors found that medications were safely and securely stored in the nurse's station. However, the temperature of medications stored in the fridge on the first floor had not been recorded on the checklist since February 2012.

3. Health and social care needs

Outcome 7

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

There was substantial compliance in relation to this outcome. Inspectors found that there was a high standard of evidence-based nursing care and that residents had access to suitable and regular services of medical and allied healthcare professionals.

Prior to admission, residents met with the provider and the person charge who carried out a pre admission assessment. These were usually done at the resident's home or in hospital. Following admission, an admission assessment was carried within 24 to 48 hours, with a range of risk factors reviewed including falls, weight, continence, balance, mobility along with social care needs, and an individual care plan was then put in place within one week.

The centre was using a computerised system to record and store information for residents including their assessments and care plans. Inspectors viewed a sample of resident's files and found the information contained for each resident was well laid out in a clear and easy to follow way. There were regular three-monthly reviews of the assessments and care plans or more frequently as required. There were notes on the files to indicate that residents and families were consulted and involved in the development of their care plans and they were invited to view the information on the computer at each assessment or review stage. However, inspectors found that the care plans were not available to residents in an accessible format and this is discussed further under Outcome 16.

All residents had access to a GP who attended the centre regularly. Residents on admission could choose to retain the services of their own GP or transfer to a local GP. Out-of-hours and weekend services were provided by the GPs. Medical notes indicated that GPs met with the residents and their families regularly in the centre. In addition inspectors saw that health needs and medications were being regularly reviewed, on at least a three-monthly basis.

Resident could receive the services of allied health care in addition to the centre's own in house physiotherapist and occupational therapist (OT). Other services referred to in residents' files included dietetic, dental, optometry, chiropody and speech and language therapy (SALT).

As discussed under Outcome 5, inspectors observed good practices in relation to the management of falls in the centre. There was evidence of regular assessment and review of care plans to manage the risk of falls. In addition, a falls prevention programme called "catch a falling star" had been introduced. Daily exercise classes were provided and residents were encouraged by staff to be as mobile as possible. Falls diaries were also in place for at risk residents.

Wound care was being effectively managed in the centre. Inspectors reviewed a sample of the files of residents at risk of developing wounds. Assessments and care plans were up to date and there was evidence of residents being reviewed by a tissue viability nurse. Staff could describe residents care detailed in their care plans. There were regular audits to identify means to improve the wound management, as discussed in Outcome 2.

Restraint was well managed in the centre. A policy was in place to guide practice. Assessments were carried out with the views of residents and relatives included in the care plans and there were regular three-monthly reviews in place. Alternatives to the use of restraints were considered and recorded. Regular checks of residents who used restraints such as bedrails were documented. Staff spoken with were knowledgeable of residents care needs as per their care plan. The provider sought to

promote a restraint free environment and undertook regular audits with a view to minimising the use of restraint measures.

The centre had good practices in place to manage behaviours that challenge. There was a weekly collection of data of all behavioural incidents that occurred in the centre and these were discussed at the weekly CNM meetings. Inspectors viewed a number of files of resident's who had challenging behaviour. Assessments were carried out using appropriate assessment tools and detailed care plans were in place to guide practice. Care plans were respectful and personal giving a descriptive account of the resident's personality and behaviour issues. They included a detailed account of the specific needs of each resident. Guidelines were in place on how to respond to behaviour issues. Where appropriate, referrals had been made to the psychiatric team. Behaviour records charts were maintained. Records of incidents and staff responses were kept. Inspectors reviewed behaviour reports and found that they gave a very detailed account of the incident. Staff responses reflected the guidelines in the residents' care plans.

Inspectors observed residents who were anxious or agitated - staff reacted in a calm and kind manner with interventions where necessary that were in line with the resident's care plan. Training had been provided in the area of dementia care to staff. Inspectors spoke with staff and found that they were knowledgeable about the care needs of each resident. They gave examples of situations where they worked together to help deescalate situations.

Residents had a broad range of activities to choose from. Inspectors met with two of the activities coordinators. They were responsible for organising the daily activities for the residents. One coordinator was based on each level. The activities programme included bingo, exercise, reading from newspapers and books and board games. The daily activities were displayed in a notice board. Residents' likes and dislikes were documented in their care plan under the activities of daily living.

Activities for residents in the dementia care unit were managed well. There was evidence of a caring, sincere approach by staff to meeting the social care needs of residents in this unit. One the day of inspection, residents in unit were involved in a number of different activities. For example, some were watching TV and looking at people passing by, another resident was having her hair done by staff and a group of residents were playing a board game with staff. To promote a more homely environment, staff did not wear uniforms but could be identified by their name badges.

To preserve residents contact with the local community, various outings were arranged including trips to a local garden centre, local shopping centres and the cinema. The person in charge told inspectors about plans for some residents, including those with dementia related conditions, to attend the annual Age Action Ireland tea party in September. The centre celebrated its 25th Anniversary in July and a BBQ had been arranged. One resident told inspectors how much she enjoyed the day and that she had been talking to one of the people from the local radio.

Twice a week musicians provided entertainment for residents. On the day of inspection residents were observed enjoying the performance and singing along with a musician was playing guitar. A resident told inspectors she loved music and sometimes would join in and get up to dance.

Animals and pets were an integral part of the centre. A pet rabbit lived on Level 1 and a budgie on level 2 at the entrance. A dog therapy charity made a weekly visit to the centre and the person in charge also regularly brought her dog to the centre. On the day of inspection, residents were observed enjoying the interaction with the person in charge's dog.

Residents could avail of additional treatments such as hand massage by an armomatherapist who came to the centre twice weekly. A hairdresser provided services in the centre two days a week and a hairdressing studio was located just off the main sitting room on the ground floor.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings
Inspectors found there was substantial compliance with this Regulation. There was a policy on end-of-life care which was reviewed by the inspector. It outlined the guidelines for assessment and care planning at end of life.

Inspectors viewed the care plan for a recently deceased resident. The records were detailed and respectfully described the resident's condition along with the family's involvement. Communication with the family and the palliative care team was documented. Families were facilitated to visit any time and stay overnight with the resident.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings
Inspectors were satisfied that each resident was provided with a nutritious diet and at times and in quantities that was suitable to their needs. Water was available at dispensers in the centre, and there was regular hot and cold drinks, snacks and fresh fruit offered to residents throughout the day. Food was prepared in the centre's kitchen by trained catering staff. Inspectors saw that the kitchen was well laid out and spacious and maintained in a clean condition. There was a plentiful supply of fresh and frozen food in the cupboards and fridges. The chef showed inspectors a four weekly menu plan. There were two main courses available for each meal with choice also offered to residents on a liquidised and pureed diet. Residents who did not wish to have what was on the menu could have something else made up. The chef said she usually went around to residents at mealtimes to see if they were satisfied with their meals, inspectors observed this on the day of inspection and residents also confirmed it. An annual food survey was also given to residents to gather their feedback on their satisfaction with the food provided in the centre.

A comprehensive nutrition policy was in place that provided information on nutrition and malnutrition and additional policies in relation to conditions such as dysphagia. These contained guidance on how to assess the nutritional status of residents. Residents had their nutrition and weight assessed using a validated assessment tool. Those at risk had care plans in place that were detailed and gave a clear description on how to manage the resident's nutritional needs. Staff were clear on the interpretation of assessment scores and the CNM explained that residents with a high MUST score and low body mass index (BMI) were included in a list of at risk residents that to be reviewed by the dietician and Speech and Language Therapist (SALT). Once their issue was being managed effectively, they were removed from the list.

At mealtimes in the centre, residents could choose to have their meals in the dining room or their own room. One resident told inspectors that she preferred to eat in her room and this was accommodated. Most residents ate their meals in the dining room. There was a dining room on each level. The large dining room on Level 2 was a large bright room and it overlooked the centre's garden. A dining area was also provided overlooking the garden in Level 1 and there was a smaller dining area provided on Level 3. Each dining area had round tables which were nicely laid with a table cloth and cloth napkins along with flower arrangements and cups and saucers that added a homely touch. A menu was on display at the entrance to the Level 2 room and there were smaller menus displayed on each table. Inspector's observed meal times in each area, and found that they were an unrushed, sociable time for residents. The meals were brought to the dining areas in a hot unit. Residents who required a modified consistency diet had their meals presented in an appetising manner, and the chef spoke about the introduction of food moulds so that mashed food portions could be presented in the shape that resembled the type of food being served. Staff were observed sitting and chatting with the residents and assisting those who required support with their meal.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings
Inspectors reviewed a sample number of contacts of care and all were agreed and signed by residents within one month of entering the centre along with outlining the services to be provided to the residents. However, they did not contain all of the required information.

The fees to be charged for the services provided by the centre were not specified in the contracts. The contracts did not clearly distinguish for residents the services that were included in the overall fee and services that had an additional fee such as personal laundry. There was also no opt-out option offered to residents for the additional required fee to cover a range of services such as physiotherapy and daily newspapers. All residents were required to pay this fee whether they availed of those services or not.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings
Inspectors found there was substantial compliance in relation to this outcome. There was provision in place for ensuring residents were consulted about the running of the centre. Resident's privacy and dignity was met overall and there were arrangements in place for receiving visitors. Residents were facilitated to communicate and exercise choice over their lives.

There was evidence of consultation with residents. Residents' council meetings were held every three months. Both residents and relatives attended the meetings. Inspectors read the minutes of a recent meeting and found examples of where issues were raised, and actions were taken to make improvements. For example, breakfast times were discussed at one meeting. Residents and staff confirmed that arrangements for breakfast had been changed following the meeting.

Voting rights were respected and the local county council were proactive in arranging for residents to cast their vote in the centre on the day of the last referendum. Residents who could not leave their room were facilitated. Politicians came to the centre to canvass.

Residents' religious rights were respected and facilitated. The majority of residents were Roman Catholic and there was a small number of residents who were Church of Ireland members. Mass took place in the centre every two weeks by a local priest and residents could received communion every Sunday. There was a small oratory available to residents in the centre. Church of Ireland ministers visited residents regularly. This was confirmed by one resident who told inspectors a room would be set aside for them on those visits.

Visiting hours were open and relaxed. Residents could meet relatives and friends in their own rooms, the main sitting room or a smaller sitting room which was available if residents wished to meet their visitors in private. Residents could also use this room for private parties if they wished.

Residents had access to one of three cordless phones in the centre to make or receive calls. Residents also had the option of having a phone fitted in their room. One resident had her own computer.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings
Overall there was adequate provision of space for residents' clothes. Each resident had plenty of wardrobe space and cupboards for personal possessions and clothes. Residents who wished to bring in their own furnishings were facilitated to do so. There was a suitable laundry service provided for washing clothes in the centre. Laundry facilities were reviewed by inspectors and were found to be well equipped and organised. Laundry staff were clear on procedures to be followed for the management of laundry.

However, improvements were required to ensure residents' clothes were returned safely to them. Some clothes in the laundry had no name tag or other marking to identify who they belonged to. The provider had introduced a new tagging system for clothes two months previous to the inspection to ensure residents clothing did not go missing, but this had not yet been fully implemented. It was very difficult to ensure that residents received their own socks back from the laundry. Socks were not labelled but were brought back in a basket to each level and then returned by staff to each resident.

Residents stated that they were satisfied with the way that their clothing was managed.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings
There was evidence that the centre was being managed by a suitably qualified and experienced nurse who had authority, accountability and responsibility. The person in charge demonstrated her knowledge of the Regulations and Standards. On the day of inspection, she could show inspectors she was competent in her role as person in charge through her knowledgeable of the welfare and the wellbeing of the residents and the organisation of the centre. She had direct access to all relevant documentation and provided these promptly. She kept her professional knowledge updated with regular training and was currently studying for a certificate in palliative care. She was covered in her absence by the provider or a CNM2.

Outcome 14
There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings
There were appropriate staff levels and skill-mix in place to meet residents' needs in the centre. Inspectors reviewed staff rosters and found that they reflected the staff on duty in the centre during the inspection. The person in charge and the CNM2 were supernumerary to the nursing staff and available to provide support and supervision to staff.

Inspectors reviewed the policy on staff recruitment and found it met the requirements of the Regulations. A sample of staff files were reviewed, including one for a recently recruited care assistant and each contained all the documentation required.

Inspectors saw a training matrix for all staff, including clinical, care and household staff. The type of training and dates each member of staff attended was recorded. Mandatory training in fire safety and evacuation and manual handling was up to date for all staff in centre. There was a broad range of training provided for staff including areas such as elder abuse, infection control, medication management, dementia care, dysphagia, nutrition, pain management and managing behaviours that challenge.

Some staff had completed further studies. For example, the provider had completed a course in dementia care mapping and one of the nurses had recently completed her Masters in Gerontology. There was ongoing education and training for health care assistants in FETAC (Further Education and Training Awards Council) Level 5 care of the elderly programme. Three staff were currently attending the programme.

All staff had participated in a virtual training exercise aimed at raising knowledge and awareness of the experience of persons living with a dementia related condition. The training involved the use of equipment to simulate a sensory and cognitive impairment. Inspectors spoke to a number of staff who had taken part in the training and they outlined the benefits they had gained, such as having a better understanding of the day to day life of a person with a dementia related condition.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

Inspectors were satisfied that the design and layout of the centre met residents' individual and collective needs. The centre was a warm, comfortable place for residents to live.

The centre was decorated to a lovely standard with extra touches added to create a warm, relaxed feel throughout. It was tastefully furnished including curtains, cushions, decorative fixtures, flowers, lamps, photos and paintings. A number of bedrooms were seen by inspectors. They were decorated to a good standard with large windows adding light to the room. There was a view from each room of the garden or the front area which was bordered by many mature trees and shrubbery.

The centre was both internally and externally maintained to a high standard. Fixtures and fittings were in good working condition. A maintenance worker was on site every Friday who kept a record of services and works carried out. Records included regular checks of equipment such as electrical lighting, kitchen ventilation unit, beds and air mattresses.

Level 1, the dementia care unit was laid out in a way to allow residents to move freely. It was decorated to a high standard with additional touches added to enhance the life of residents with a cognitive impairment. These included old signs from days gone by, an old-fashioned clock, and doors to bedrooms were painted different colours and photos and painting on them to assist with orientation for residents. The walled garden was directly accessible from the dining room.

Improvements had been made to lighting in the dementia care unit. New lighting had been installed in corridors to make them brighter and more pleasant and new lighting was in the process of being installed in the sitting room to the rear of the unit. However, a number of bedrooms and this sitting room had their visibility and light blocked by a wall directly outside their windows. This issue had been identified in the previous inspection and had not yet been addressed. The person in charge outlined plans in relation to these rooms affected by the wall. It would involve reducing the size of the room and installing patio doors to create more space between the rooms and this external wall.

On the day of inspection communal rooms in the centre were very warm and uncomfortable. This matter was brought to the attention of the person in charge. She explained that the provider was aware of the matter and it had also been raised by some residents. A number of fixed fans had recently been installed in the Level 2 sitting room along with portable fans in other parts of the centre. The provider was monitoring the effectiveness of these measures and additional fixed fans would be provided if the current fixed fans proved successful.

There was one multi-occupancy bedroom on Level 3 for four residents. The person in charge was aware of the requirement of the Standards that there are to be no more than two residents per room except in certain exceptional circumstances, and that the Standard must be implemented by June 2015.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Part 6: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings
Inspectors found that all information and records required by the Regulations were in place, the centre was adequately insured. However, some improvements were required.

The summary of the complaints procedure in the Residents' Guide did not provide adequate information on the complaints process for residents. Additional information to guide residents in this regard was needed such as the name and contact details of complaints officer and the appeals person.

Although all policies and procedures as required by the Regulations were in place some polices reviewed by Inspectors did not reflect the work practices of staff. For example, personal finances policy and the end of life policy were not centre specific.

As mentioned in Outcome 7, Inspectors found that residents' care plans were not available in a format that was accessible to residents and appropriate to their needs in order to assist in their decision making.

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings
There was substantial compliance found. Notifications were submitted to the Authority when required and within the timeframe specified in the Regulations.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings
The provider was on leave at the time of this inspection. However, as reported in the previous inspection, the Provider was aware of the requirement to notify the authority of any notifiable absence of the person in charge. At the time of this inspection there was no requirement to notify the Authority of the absence of the person in charge as no such situation had presented itself.

Closing the visit

At the close of the inspection visit a feedback meeting was held with Julie Fuller the person in charge and Christina Aberilla CNM2 to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the co-operation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Deirdre Byrne

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

20 August 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Lucan Lodge Nursing Home
Centre ID:	0061
Date of inspection:	13 and 14 August 2012
Date of response:	26 September 2012

Requirements

These requirements set out the actions that must be taken to meet 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*.

Outcome 4: Safeguarding and safety

1. The provider is failing to comply with a regulatory requirement in the following respect: The procedures that were in place to protect residents' personal finances were not adequate.	
Action required: Put in place all reasonable measures to protect each resident from all forms of abuse.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
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: Changes to practice have been made and policy now reflects these changes.	20/08/2012

Outcome 5: Health and safety and risk management

2. The provider is failing to comply with a regulatory requirement in the following respect: Risk assessments were insufficient to ensure all risks in the centre were effectively managed for example brakes applied on trolley and foot plates used on wheelchairs. Fire safety precautions were not fully implemented for example the records of daily fire exits were inconsistently documented and records of fire practices did not contain sufficient detail.
Action required: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.
Action required: Maintain, in a safe and accessible place, a record of all fire practices which take place at the designated centre.
Action required: Make adequate arrangements for detecting, containing and extinguishing fires; giving warnings of fires; the evacuation of all people in the designated centre and safe placement of residents; the maintenance of all fire equipment; reviewing fire precautions, and testing fire equipment, at suitable intervals.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems

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

Provider's response: Risk management policy updated to include trolleys and wheelchairs. A more detailed record of fire drill is now been kept. Person in charge has now allocated the daily checking of exits to housekeeping supervisors and the monthly checking of door release to electrician and will keep this under review.	19/09/2012

Outcome 6: Medication management

3. The provider is failing to comply with a regulatory requirement in the following respect: The temperature of medications stored in the fridge in Level 2 was not recorded.
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Nurses have been re-educated regarding the importance of consistent recording of fridge temperature.	20/08/2012

Outcome 10: Contract for the provision of services

4. The provider is failing to comply with a regulatory requirement in the following respect: The contract of care did not contain all information required by the Regulations, such as the fee to be charged, nor did it clearly outline the services to be included in that fee and those that would incur an additional fee.

Action required: Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Services Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Being implemented.	 30/09/2012

Outcome 16: Records and documentation to be kept at a designated centre

5. The provider is failing to comply with a regulatory requirement in the following respect: The Residents' Guide did not contain a summary of the complaint procedures to be followed. Not all policies reflected the staff practices. Residents care plans were computerised and may not be fully accessible or in a format to meet the needs of residents.
Action required: Produce a resident's guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.
Action required: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.
Action required: Ensure each resident has access to information to assist in decision making, including, but not limited to, the information specified in the Regulations. Provide this information in an accessible format, appropriate to each resident's individual needs.

Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Regulation 27: Operating Policies and Procedures Standard 1: Information Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Residents' Guide now has full complaints procedure. Regarding finance policy residents now counter sign for all money left for safe keeping or the withdrawal of same. Having spoken to residents and families they are happy to continue with current procedure and have no wish at this time for hard copies of their care plan they will continue to discuss care on an on-going basis with nursing staff. They can at any time request a hard copy.	 14/08/2012 15/08/2012 19/09/2012

Any comments the provider may wish to make:

Provider's response:

Person in charge and CMN would like to thank the inspection team for their positive attitude.

Provider's name: Tanya Patterson
Date: 24/09/2012