

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Laurel Lodge Nursing Home
Centre ID:	OSV-0005394
Centre address:	Templemichael Glebe, Longford.
Telephone number:	043 334 8033
Email address:	laurellodgelongford@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Templemichael Nursing Home Limited
Provider Nominee:	Rosetta Herr
Lead inspector:	Sonia McCague
Support inspector(s):	Leanne Crowe;Una Fitzgerald
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	105
Number of vacancies on the date of inspection:	2

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 10 March 2017 08:00 To: 10 March 2017 17:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Provider's self assessment	Our Judgment
Outcome 05: Documentation to be kept at a designated centre		Non Compliant - Major
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant

Summary of findings from this inspection

As part of the thematic inspection process, providers were invited to attend information seminars given by the Health Information and Quality Authority (HIQA). In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the provider's self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016). The previous table outlines the centre's rating and the inspector's rating for each outcome.

The inspectors met with residents and staff members during the inspection. The

journey of a number of residents with dementia within the service was also tracked. A validated observation tool was used to observe practices and interactions between staff and residents who had dementia. Documentation such as care plans, medical records and staff training records were also reviewed.

Laurel Lodge Nursing Home is purpose built and provides residential care for 107 people and a day service to a maximum of two private residents daily to the dementia unit. Approximately 55% of residents had a diagnosis of dementia and a further 16 residents were suspected as having dementia.

The inspector observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. The living environment in general was stimulating and also provided opportunities for rest and recreation in an atmosphere of friendliness.

The inspectors found that residents had a comprehensive assessment undertaken on admission and care plans were in place to meet their assessed needs, although some improvement was required to ensure that they were updated to reflect end of life arrangements and a resident's changing condition and interventions following an incident.

Inspectors were satisfied with the assessment and management of restraint and responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). However, the high occupancy level of 38 residents with a diagnosis of dementia within one unit was not an optimal arrangement or in accordance with national averages (19) reported or in line with international averages of 12 residents in small scale domestic style units. This arrangement required review.

Measures were in place to protect residents, however, the policy and procedure to respond to allegations, disclosures and suspicions of abuse was not sufficiently robust to guide and ensure all required details and necessary steps were taken when an allegation or suspicion of abuse was reported.

While staff and the design and layout of the premises promote the dignity, wellbeing and independence of residents with dementia, the provider needs to address the identified areas for improvements outlined within the report.

Staff were observed to be courteous and responsive to residents and visitors during the inspection. A range of staff training opportunities included dementia specific training courses. There was appropriate staff numbers to meet the needs of residents during the inspection but areas for review and improvement in relation to the skill mix, supervision and training gaps found was required.

There was a recruitment policy in place which met the requirements of the Regulations. However, there was no evidence of Garda Síochána Vetting for one staff member working in the centre on the day of the inspection. This staff member was immediately removed from their duties by the Operations Manager as the provider's

representative. The Operations Manager also confirmed that they would not resume work until Garda Vetting had been fully processed and all other staff had Garda Vetting in place.

While arrangements for residents to be consulted with and participate in the organisation of the centre on a day-to-day basis was seen and described, further work was required in this regard.

The results from the formal and informal observations were encouraging, but some additional work was required to ensure that the majority of staff interactions with residents promote positive connective care.

The management of complaints recorded was in line with the requirements of the regulations. HIQA was in receipt of five separate submissions of unsolicited information alleging poor standards of care and practices. The provider representative and management staff were informed of the information received to inform their audits and review of care and staffing.

Some of issues highlighted within unsolicited information received was seen reflected in the complaints logged, however, inspectors did not find sufficient evidence to concur with all the issues highlighted but improvements were required following this inspections findings that included the maintenance of records and correspondences about residents.

The overall findings are discussed further in the body of the report and 23 actions required are included in the action plan at the end.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.***

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The centre's statement of purpose and evidence of Garda Vetting for all staff were the only aspects of this outcome that were reviewed on this inspection.

An updated statement of purpose had recently been submitted but this did not accurately reflect the staffing levels in the centre on the day of the inspection.

On the day of the inspection, it was found that one recently recruited staff member did not have Garda Vetting in place. This staff member was immediately removed from their duties, and the Operations Manager confirmed that they would not resume work until Garda Vetting had been fully processed. The Operations Manager also confirmed that all other staff had Garda Vetting in place on the day of the inspection.

Judgment:

Non Compliant - Major

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

This outcome sets out the inspection findings relating to clinical assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The social care of residents with dementia is reported in Outcome 3.

The self assessment tool (SAT) completed by the provider was rated compliant in this outcome with no areas for improvement highlighted.

There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Comprehensive assessments with respect to the health, personal and social care needs of all new residents was carried out immediately before or within 48 hours of the person's admission and care plans developed accordingly.

The assessment process involved the use of validated tools to assess each resident's dependency level, cognitive status, falls risk and skin integrity. The centre catered for residents with a range of healthcare needs and has a dedicated unit that caters for up to 38 residents with dementia. Inspectors focused on the experience of residents with dementia living in the centre. They tracked the journey of a sample of residents and reviewed specific aspects of care such as safeguarding, nutrition, access to allied health services and end-of-life care planning. Care plans reviewed were noted to be person centred.

While there was no resident receiving end of life care on the day of inspection the care plans which were examined, showed that the residents and their families had been consulted on matters of what their wishes should be. Issues like preferred place of death were discussed. The inspector also saw clear evidence that the resuscitation status of residents was reviewed and documented. The religious and cultural need of the residents was also documented. While all the care plans examined in the dementia specific unit held an end-of-life care plan, an end-of-life care plan which reflected the wishes of residents and family members was not complete for all residents accommodated in another unit.

Systems were in place to prevent unnecessary hospital admissions. Residents were protected by safe medication management policies and procedures. In the main, care plans contained the required information to guide the care of residents, and were updated routinely in line with the requirements of the regulations or sooner if clinically indicated. However, in one of the resident's notes reviewed some improvement was required to ensure the care plan was revised and updated following a fall and serious injury to include the assessment and identification of control measures and support equipment required.

Family members confirmed that they participated in the care plan reviews. Positive health and wellbeing was promoted for residents.

There was evidence that residents received timely access to health care services. The person in charge confirmed that a number of local General Practitioners were attending to the needs of residents in the centre. Residents had good access to allied healthcare

professionals including psychiatry, occupational therapy, dietetic, speech and language, ophthalmology, dental and chiropody services. Residents in the centre had access to specialist palliative care services for support with management of their pain and for symptom management during end-of-life care as necessary. A suitable pain assessment tool was available for residents with dementia. Inspectors tracked a number of residents' files.

Common Summary Assessments (CSARs) documentation which details pre-admission assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme were not routinely obtained for residents admitted from the hospital setting for long-term care. However, the deputy person in charge confirmed with the inspector that this detail is reviewed as part of their pre-admission assessment completed by the person in charge or his deputy. The files of residents' admitted from hospital held their hospital discharge documentation.

Residents who were transferred to hospital from the centre had a discharge document template that contained information about their health and medication needs. This document did not adequately address triggers that direct care for residents with dementia who cannot advocate for themselves independently. The inspector spoke with the assistant director of nursing (ADON) who agreed that they will review this document. In addition, all records relating to a resident and correspondence to and from the centre to their ward of court representative was not readily available for inspection.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently if clinically indicated. There was access to a safe supply of fresh drinking water at all times. Inspectors saw that residents had a choice of hot meals. The staff confirmed that alternatives were also available to the menu available each day if residents did not like the meal choices on offer. The menu was varied and was displayed in written text on the dining room notice board. However, pictures aids of food available on the menu were not seen available to illustrate and provide a guide to residents with communication difficulties in expressing their choice of dish. A variety of drinks were made available to residents at mealtimes and inspectors observed that some residents also enjoyed refreshments outside of scheduled mealtimes. The inspector reviewed the diet sheet for a newly admitted resident and food preferences along with food consistency were clearly documented. There were arrangements in place for communication of residents' dietary needs between nursing and catering staff to support residents with special dietary requirements. Residents on specialised diets such as diabetic, fortified and modified consistency diets and thickened fluids received their correct diets and fluid consistencies. For the most part residents received discreet assistance from staff with eating where necessary. However, one resident with behaviour that challenges was seen sitting in isolation facing a wall. This did not demonstrate social inclusion and appropriate support at this time. This is dealt with under Outcome 2 of the action plan.

Residents identified at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions. There were two resident with pressure ulcers (Grade 1/2) and three residents

reported with wounds at the time of inspection and a treatment plan was in place. The person in charge told inspectors that he had completed a course on the management of wounds and the need for a tissue viability specialist had not been required but was available.

Residents were protected by safe medicines management practices and procedures. There was a written operational policy informing ordering, prescribing, storing and administration of medicines to residents. While the current residents were availing of the services of one pharmacy, the PIC confirmed that residents did have the choice to remain with their current supplier and this was being accommodated for three residents. Practices in relation to prescribing and medicine reviews met with the legislation and regulatory requirements. Nursing staff were observed administering medicines to residents and practices reflected professional guidelines. Appropriate storage and checking procedures were in place for medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage. Residents who required their medicines to be crushed were signed off by the GP and resident or family consent was obtained. Inspectors were informed by management that the use of PRN (as required) medicines had reduced. While this was acknowledged by inspectors, it was noted that PRN medicine prescribed for one resident did not state the maximum dose to be administered within a 24hour period.

The centre had a system in place for recording and managing medication errors. On inspection the Person in Charge (PIC) informed the inspector of a medication error that recently occurred. On examination of the incident document recorded, and following a review of the resident's records and discussions with staff, inspectors concluded that the management of medication errors required improvement. Steps taken to inform the resident or significant other were unclear and documentation regarding the monitoring and response taken and preventative measures put in place to minimise the risk of reoccurrence were not sufficiently recorded to demonstrate appropriate nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais. A detail of the medicine incident was not recorded in the resident's daily progress notes to communicate to other staff. The registered provider gave assurance that the incident will be followed up and appropriate action taken if deemed required.

A further improvement was required in relation to the time the night report was completed by staff. Inspectors noted entries by night staff being completed by nurses up to seven hours prior to the shift end. For example, an entry by a night nurse was made at 01:15hrs for duty ending at 08:00 hrs (8am). This early entry does not provide a summary of care provided throughout the night and up to the end of the duty by the responsible person.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The self assessment tool (SAT) completed by the provider for this outcome was rated compliant with no areas for improvement identified.

The centre had a policy on and procedures in place for working with residents who have behaviour that is challenging. This policy is informed by evidence-based practice and implemented by staff. Staff adopted a positive, person centred approach towards the management of behaviours that challenge. Because of their underlying condition some residents showed behavioural and psychological signs of dementia (BPSD). Care plans tracked were individualised and guided care. Efforts are made to identify and alleviate the underlying causes of behaviour and psychological symptoms of dementia. Staff spoken with by inspectors was knowledgeable on the residents triggers and were able to voice the appropriate intervention management as per the residents care plan.

Inspectors saw that residents that were identified to be at risk of absconion had hourly monitoring in place and this was clearly documented. The provider representative later informed inspectors that 15minute monitoring of residents was also carried out for residents at risk. During the inspection staff approached residents in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff.

The centre promotes a restraint free environment. Additional equipment such as low level beds and sensor alarms were available and in use by some. The inspectors reviewed the care plan of one resident currently using a lap belt. The care plan was comprehensively written and guided practice. A falls risk assessment had been carried out. There was evidence of GP and family involvement and a signed consensus was in place. This care plan was reviewed at required intervals. Some residents were prescribed antipsychotic or mood altering medications to treat an underlying condition. Within the dementia specific unit the inspector tracked the use of these medicines. The inspector found that the use of PRN medications was carefully monitored and used as a last resort when other person centred interventions had failed. The inspector tracked one administration and found that the rationale for the administration and the effectiveness of the medication given was clearly documented. It was also noted that the clinical team requested a medical follow up review which was carried out the following day.

The centre had policies in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. However while there was a policy, procedures and practice in place some gaps were seen in how the documents were maintained. Staff had received training on identifying and responding to elder abuse. Staff spoken to were clear about who they would report any concerns too. On the day of inspection the inspectors were informed of an allegation that had been reported to the ADON. However, HIQA had not been notified of this allegation within the

3 days notice period required. On review of the policy it was discussed with the registered provider and improvements were required in relation to the policy. The policy did not properly explain the procedures to be put in place to support and protect residents with dementia in the event of an allegation of abuse. The policy was not robust to guide and ensure the required details and necessary steps were taken when an allegation or suspicion of abuse is reported. The PIC was aware of the incident. A notification of the incident was subsequently submitted to HIQA indicating an investigation into the allegation was on-going.

There inspectors spoke with staff on how residents funds were managed. The centre was a pension agent for one resident. While there were procedures and practices in place to keep residents' money safe, some gaps were evident. Systems were in place to demonstrate all transactions. However, staff involved and spoken to was unclear on how a resident would access their funds at a time of their choosing. The inspectors brought this to the attention of the registered provider who was to follow up and address.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The self assessment tool (SAT) was rated compliant in this outcome and the action plan response did not include an area for improvement.

A communication policy was available that included information to promote communication with residents and relevant others, and provided staff guidelines in relation to the governance and management of communications. Arrangements were in place for residents with dementia to access advocacy services.

Arrangements for residents to be consulted with and participate in the organisation of the centre on a day-to-day basis were described. A system where each resident had a key nurse responsible for assessing and reviewing their abilities and needs was in place. Staff were allocated to provide care and support a number of residents on a daily basis. Staff who spoke to inspectors knew residents and their relatives well, and residents were familiar with the staff and nurses in charge of their unit.

A structured forum for residents to meet and discuss issues was described in the centre's policies and information documents. However, the forum arrangement was infrequent, the minutes of the most recent meeting was not available. The most recent

minutes available were 2015. The provider representative informed inspectors that 'At a residents forum meeting on the 10th August 2016 it was voted by the residents to move the meetings to quarterly until further notice and that in the meantime additional adhoc meetings could be arranged or the frequency increased if desired'.

Inspectors were told the residents meeting was generally carried out to include representatives for all (107) residents living in the centre and meetings took place in the library on Lissadell unit. On examination of this room inspectors concluded the library which could accommodate up to 20 people comfortably which may not accommodate sufficient or proportional numbers. Inspectors recommended a review of the current arrangements as the residents' forum arrangement could not cater for all residents within each unit particular to their lived experience. The resident profile varied between units and their ability to participate would vary also. For example, Lisadell was described as a unit for long stay residents, Hazelwood was for convalescent and Glencar was a dementia specific unit. Inspectors recommended opportunities and invitations to relative representatives to attend and advocate on behalf of residents with cognitive impairment, communication problems or as support, if appropriate as 55% of residents had a diagnosis of dementia and a further 15% were suspected as having a dementia related illness.

Inspectors were informed by managers that a satisfaction survey had been issued to relatives earlier this year for review or dissemination within a report. In conversations with inspectors both residents and relatives expressed satisfaction with the service and staff on duty.

Arrangements were in place to promote residents' privacy and dignity, and many residents were supported to make choices and to be independent. There were opportunities for residents to participate in group and individual activities that suited their interests. Residents were heard opting in and out of activities when offered. An individual resident whose journey was tracked by inspectors had reasonable support to promote their quality of life with some improvement needed to promote independence following a serious injury due to a fall in the centre. Inspectors reviewed the accident and clinical records of this resident since admission. The assessment following the fall identified specific equipment such as an alarm device as a control measure required to reduce the assessed high risk of falls and potential reoccurrence. However, this device had not been provided and there was no recorded or communicated information in relation to this identified need within the residents care plan or progress notes. This is included in the action plan for Outcome 1.

The quality of life for many residents in the centre was enhanced by their engagement with visitors on a regular basis and participation in meaningful activities such as prayer, music, games, pottery, painting, bingo, sonas and gentle physical exercises. The centre had internal outdoor areas that were secure, accessible and suitably furnished with interesting features such as bird feeders, hens and a coop and winding path-ways. Inspectors were shown plants and flower pots and were told that they had been recently delivered for transfer and planting in the flower beds. Residents were to be involved in this activity as many enjoyed the outdoors and gardening.

There were four dedicated activity staff members to co-ordinate a programme of

activities for each unit. One of the activity staff members was attending a training course related to her role on the day of inspection. Care staff supported by activity staff considered residents' wishes when planning activities and events. The daily routine for some residents' was informed by their wishes and preferences communicated to staff on the day. A weekly programme of activities was planned and displayed within each unit.

Inspectors observed the quality of interactions between staff and residents in the three units throughout the inspection. A validated observational tool was used by inspectors during formal observation periods to rate and record the quality of interactions between staff and residents. Observations where a large group attending mass and a smaller group of residents in a bingo activity showed evidenced of a high rate of positive connective care. Staff provided good quality interaction that demonstrated positive connective care which benefitted the majority of residents involved. However, task orientated or neutral care was also noted in observations undertaken such as during and after meal times. At this time, staff were primarily focused on the task of serving, delivering and collecting dishes with little positive or meaningful interaction to enhance the social occasion for residents. Therefore the meal time experience required improvement as a meaningful activity.

A group activity such as mass and bingo was seen to be a positive experience for residents, but another large group activity or gathering was not. For example, group activities for residents sensitive to high levels of noise and stimuli had activities carried out in an open planned communal area that served multiple purposes required review. This arrangement was not optimal to support meaningful positive engagement. For example, the dementia specific unit catered for up to 38 residents and inspectors learnt that a day service was offered to a maximum of two persons daily. A group activity involving up to 21 residents was seen arranged in the large day room. Other residents were also in this room that had high ceilings. The bowling activity was seen to be interrupted a number of times due to people/visitors and residents entering and leaving the room, and due to the high level of noise being generated. During discussions with the provider representative at feedback she told inspectors of plans to divide this area and room. She also acknowledged that a high occupancy level of 38 residents with a diagnosis of dementia was not an optimal arrangement. An occupancy level of 38 to 40 residents in a dementia specific unit is not in accordance with national averages (19) reported or in line with international averages of 12 residents in small scale domestic style units. This arrangement required review.

During the course of the inspection the inspectors found that each resident's privacy and dignity was respected in relation to receiving visitors, provision of intimate care and support, medical consultations and access to bedrooms, bathrooms and toilets. Staff addressed residents in a respectful manner and residents' rights were facilitated and promoted by staff that knew about the cultural background of each individual resident they worked with. Staff were observed to be courteous and responsive to residents and visitors. Staff were seen knocking on resident's bedroom doors before entering. Residents with dementia were supported to observe or abstain from religious practice in accordance with their wishes. A large spacious chapel formed part of the centre where mass was provided four times weekly that included people attending from the locality and wider community.

Residents' clothing and regard to their state of dress was appropriately maintained to meet their needs, dignity and rights.

There were many visitors in the centre on the day of inspection and there were a number of areas where residents could meet with visitors in private. Family members told inspectors they were welcomed when visiting despite seeing memos erected on dining room doors stating no visiting at mealtimes. A record for visitors to record visits to the designated centre was available and maintained at the front entrance. However, visitors were seen entering via a side entry via a coded door for mass and a visitor's record was not seen at this entry point.

Communication devices and aids were used by some residents to help communicate such as hearing aids and spectacles. Some residents had access to a private telephone for their personal use, while others were facilitated by staff to use the centres telephone to communicate with their relatives. Inspectors were told by staff that internet was available and accessible throughout the centre, however, mobile or visual internet communication devices such as an iPad or laptop to facilitate 'skype' visual and audio communications was not available for use unless brought in by a visitor. The improvements required to increase the availability of visual aids and equipment to enhance communication aids and promote the availability of devices was acknowledged by the provider representative as an area in need of improvement to enhance communication and way finding for residents with dementia.

Information about the centre was available. There were notice boards available throughout the centre and in each unit providing information to residents and for visitors. Radios, televisions and newspapers were available for information about current affairs and local matters. Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities of living and this was noted in interactions observed.

Hairdressing arrangements were available up to four days per week to support residents personal grooming. On the day of inspection two hairdressers were providing services to residents of the centre which was considered a valuable service by residents.

Independent advocacy services and contact details were also displayed to support all residents including residents' families to raise issues of concern. Inspectors were told by staff that none of the current residents were involved with or being supported by an advocate.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors saw that there were policies, procedures and systems in place for the management of complaints and concerns.

The complaints procedure was publicised throughout the designated centre and residents and relatives who communicated with the inspectors were aware of the process and some identified the person with whom they would communicate with if they had an issue of concern.

The procedure identified the nominated person to investigate a complaint and the appeals process. The person in charge was the nominated complaints officer and the provider representative was the person nominated for appeals. The ombudsperson was the next step if not satisfied with the appeals outcome. Inspectors recommended a review of the appeal arrangement to provide a more independent review of investigations as the provider representative was actively involved in the governance of the service and the person who staff report to in the person in charge's absence.

The inspectors examined the complaints record and found that the procedures were followed and records available highlighted the outcome for the complainant and resolution.

A change in the provider had occurred since the previous inspection. Since then, HIQA was in receipt of five separate submissions of unsolicited information which alleged poor care practices and responses in relation to the management of complaints, poor standards of care, inappropriate transfer of residents between units when approaching end of life, poor hygiene standards and staffing concerns. The provider representative and management staff were informed of the information received to inform their audits and review of care and staffing.

Some issues highlighted within unsolicited information received had also been reflected in the complaints seen logged, and while improvements were required following this inspection, the inspectors did not find sufficient evidence to concur with all the issues of concerns highlighted.

Inspectors were told by the provider representative about a recent complaint that was active and under investigation. The management of this complaint will be followed up at the next inspection as the details of the investigation or meetings held were not available in the complaints file.

In relation to the concern raised regarding a resident transferred at the end of their life from a unit where they had lived for years, inspectors were told by the provider representative and person in charge that residents were rarely transferred between units. However, the number of resident transfers within the centre or between units was unknown. The person in charge agreed to calculate transfers and submit the findings to HIQA for review.

Judgment:

Substantially Compliant

Outcome 05: Suitable Staffing**Theme:**

Workforce

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that there was a sufficient number of staff on duty on the day of the inspection with the appropriate skills, qualifications and experience to meet the assessed needs of residents, including those with dementia. However, some improvements were required.

A review of the statement of purpose submitted at the time of registration in 2016 with an amended versions submitted in 2017 showed changes in the overall whole time equivalent (WTE) staff provision affecting staff numbers and skill mix. From a review of the staff roster and discussions with staff, inspectors found that the whole time equivalent staffing levels for nurses and nurse managers had reduced. Inspectors were informed that this was attributed to a turnover of staff which resulted in an ongoing recruitment drive aimed at increasing the existing nurse WTEs and to restores nurse staffing levels to facilitate supernumerary status to senior nurses and nurse managers on each of the three units. Inspectors were told that the recruitment of up to four staff nurses was being processed and was to be complete by the end of April 2017. An application submitted to HIQA with plans proposed to increase resident occupancy and staffing later this year has been made.

There was an actual and planned roster in place, with changes clearly indicated. The roster showed there was a nurse rostered on duty at all times. On the day of the inspection a nurse was on duty and rostered to work on each of the three units. Inspectors were informed by the person in charge that a minimum of one nurse was rostered to each unit at all times (day and night) and that an additional nurse was rostered daily to the dementia specific unit where dependency and activity levels were greater. A review of staff shift patterns is recommended to ensure adequate rest periods were maintained between shifts. For example, some staff completed their working shift at 10pm and were rostered to return on duty at 8am, within ten hours.

Policies were in place for the recruitment, training and development of staff. A sample of staff files were reviewed by inspectors, and these were found to contain all of the information required by Schedule 2 of the regulations, including evidence of Garda Síochana Vetting. However, one new staff member working in the centre on the day of the inspection did not have Garda Vetting in place, an action relating to this is featured in Outcome 2.

All nursing staff were found to have up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann.

There was a system in place for the induction of newly-recruited staff, which included close supervision and regular performance reviews. Annual appraisals were conducted on an ongoing basis, and a sample of these were seen by inspectors. However, improvement was required to ensure adequate supervision, monitoring and support was in place for staff following an incident such as a medication error.

A training programme was in place for staff which included mandatory training in fire safety, moving and handling practices and the prevention, detection and response to abuse. A transition from paper-based to electronic training records was ongoing at the time of the inspection. While training records were made available to inspectors for review, these were incomplete as they did not feature all staff that were recorded on the staff roster. According to training records, while a majority of staff had completed up to date mandatory training in line with the regulations, a small number of staff had not completed this training. Records indicated that many staff members had completed training in dementia care and the management of responsive behaviours and the operations manager informed inspectors that training in restrictive practices, dementia care and responsive behaviours was scheduled for the coming weeks. Training records required some improvement to effectively identify staff who have completed or require training as needed.

Inspectors were informed by the provider nominee that there were no volunteers operating in the centre at the time of the inspection.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The premises met the needs of residents and efforts to create a homely environment for all residents were clearly visible throughout the centre. However, further improvement to the premises' design was required to ensure the dignity, independence and wellbeing of residents with dementia was promoted. Inspectors acknowledged that refurbishment works are planned for the centre, which may address some of the issues identified on the inspection.

Laurel Lodge is purpose built accommodation for 107 residents. The centre comprises three units; Lissadell Lodge which accommodates 33 residents, Hazelwood Lodge which accommodates 36 residents and Glencar Lodge, which is a dedicated Dementia and Alzheimer's unit providing accommodation for 38 residents. Resident accommodation was located on two floors; 14 bedrooms and communal facilities were located on the first floor of Lissadell Lodge.

There was bright and spacious recreational and dining space for residents, with each unit containing a number of communal spaces. A large chapel was located in the building and a number of enclosed outdoor areas were also located throughout the premises, which were accessible to residents. A hairdressing room had been well-decorated in the style of a salon. Bedroom accommodation for residents comprises a large number of single bedrooms and six twin rooms. Most bedrooms had ensuite facilities, but those that did not were located in close proximity to appropriate facilities.

Residents' bedrooms included sufficient storage facilities as well as any specialised or assistive equipment that may be required. Heat, lighting and ventilation were adequate and the temperature of the building met requirements in bedrooms and communal areas where residents occupied during the day.

Overall, the building was clean and nicely decorated and efforts had been made to create a dementia-friendly environment. For example, a number of rooms in Glencar Lodge were decorated in the style of a bedroom and kitchen from the early 1900's to support residents' reminiscence, and a therapeutic room was also present. A number of hens were kept in one of the several outdoor spaces in Glencar Lodge.

There was ample indoor space in the centre for residents to walk about, and large murals and other objects, such as a weaving loom, were displayed throughout all three units to engage residents as they did so. However, the use of colour schemes required enhancement throughout the building. For example, the use of contrasting colours in corridors and on assistive equipment in toilets required improvement.

While some signage and cues were used, more appropriate signage was required to support residents to navigate the centre and locate their bedrooms. Some, but not all residents' bedrooms were personalised in an individual way, and many rooms did not contain clocks or calendars to orientate residents to time and place.

Efforts were made to control stimuli such as glare and noise throughout the premises but improvement was required to reduce noise levels in the dining room of Glencar Lodge, as discussed in Outcome 3. A small amount of areas requiring maintenance work was identified on the day of the inspection. The provider nominee told inspectors that a log of such work was maintained in the centre for address.

Improvement was required in the cleaning of some sanitary facilities to ensure compliance with infection control standards.

Sluicing facilities were present in all three units. Access to these rooms required review and improvement as they were not consistently restricted throughout the day to ensure residents could not come into contact with hazardous materials.

Handrails were available in all circulation areas throughout the building, and grab rails were present in all toilets and bathrooms. A lift was available for movement of residents between floors.

All bedrooms had call bells fitted, and these were also seen in toilets and bathrooms inspected.

Appropriate cooking facilities and equipment were located in the centre. There were a number of laundry rooms and while these were small it is acknowledged that these were only used for the laundering of residents' personal clothing.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Sonia McCague
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Laurel Lodge Nursing Home
Centre ID:	OSV-0005394
Date of inspection:	10/03/2017
Date of response:	10/04/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The centre's statement of purpose did not accurately reflect the staffing levels on the day of the inspection.

One recently recruited, staff member working on the day of the inspection did not have Garda Vetting in place.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

The statement of purpose will be reviewed and amended. The member of staff in question was immediately removed from duty and replaced with another so as not to negatively impact resident care. She has since returned to duty with her Garda clearance in place. An amendment has been made to our HR pathway to protect against this oversight happening again.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

- The review of the SOP will be complete and forwarded to the authority by the 14th April 2017
- Complete

Proposed Timescale: 14/04/2017

Outcome 01: Health and Social Care Needs**Theme:**

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Inspectors found that the management of medication errors required improvement. Steps taken to inform the resident or significant other were unclear and documentation regarding the monitoring and response taken and preventative measures put in place to minimise the risk of reoccurrence were not sufficiently recorded.

2. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:

A review of our incident record sheet has commenced which will ensure an appropriate location for this information going forward. We are also undertaking a review of the RN's skills competencies and will take appropriate action as required. With regards to the error mentioned, the investigation following the incident indicated a point of risk which has since been removed thus ensuring no further errors of that kind.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

- The review of the incident record sheet will be complete by the 28th April 2017 and will be in use across the home by the 5th May 2017. The incident sheet will now trigger a review of skills / competencies if indicated and the usual HR pathway will apply.
- The use of the RN skills competencies form will be added to all incidents where there is an issue with competencies effective from the 5th May 2017.

Proposed Timescale: 05/05/2017

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A resident's notes reviewed required improvement to ensure the care plan was revised and updated following a serious injury and to ensure the specific equipment such as an alarm device that was identified as a control measure was provided as assessed to reduce the high risk of falls and injury.

3. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:

The paperwork in question has been updated and the nurse responsible reminded of her responsibilities in this regard. The care plan audit cycle has also been increased to assist in capturing good or poor practice.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

- The amended paper work was done
- This issue was raised at a nurses staff meetings held and has also be added to the daily handover highlights for a period of time.
- The care plan audit is changed to monthly effective from the 1st May 2017 and will be reviewed after 6 months.

Proposed Timescale: 01/05/2017

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

An end-of-life care plan which reflected the wishes of residents and family members

was not complete for all residents.

4. Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:

Work has commenced on the few remaining residents which we hope will be completed by the 31st May 2017 subject to the wishes of and cooperation from residents and/ or their family member.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

To be completed by 31st May 2017.

Proposed Timescale: 31/05/2017

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Pictures aids of food available on the menu were not seen available to illustrate and provide a guide to residents with communication difficulties in expressing their choice of meal or dish.

5. Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:

The Picture aides have been removed from the dining room dresser and are now on tables around the dining room where they can be easily seen by staff and residents. Staff have also been reminded of their availability and their use via daily handovers.

This issue was included in a management meeting agenda on the 10th April 2017.

Proposed Timescale: Complete

Proposed Timescale: 10/04/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Improvement is required in relation to the time the night report is completed by staff. Inspectors noted entries by night staff being completed by nurses up to seven hours prior to the shift end. This early entry does not provide a summary of care provided throughout the night and up to the end of the duty by the responsible person.

6. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

This issue has been brought to the attention of all nurses and the policy on documentation will be amended accordingly.

This issue was included in a management meeting agenda on the 10th April 2017

Proposed Timescale: The new policy will be in place by the 31st May 2017

Proposed Timescale: 31/05/2017

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The discharge document did not contained sufficient information about residents health and medication needs. It did not adequately address triggers that direct care for residents with dementia who cannot advocate for themselves independently.

All records relating to a resident and correspondence to and from the centre to their ward of court representative was not readily available for inspection.

The number of resident transfers within the centre or between units was unknown. The person in charge agreed to calculate transfers and submit the findings to HIQA for review.

7. Action Required:

Under Regulation 25(1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre for treatment at another designated centre, hospital or elsewhere, to the receiving designated centre, hospital or place.

Please state the actions you have taken or are planning to take:

The discharge letter content and format are under review to ensure this information is captured going forward.

The soft copy document was printed off the computer after the inspection and is in

place in the residents file.

The internal transfers were examined and calculated and a report sent to the authority.

This issue was included in a management meeting agenda on the 10th April 2017

Proposed Timescale:

- The up-dated transfer letter will be complete and in circulation by the 31st May 2017.
- This document was printed off the computer and added to the file on the 15th March 2017
- Complete.

Proposed Timescale: 31/05/2017

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

PRN medicine prescribed for one resident (in the sample reviewed) did not state the maximum dose to be administered within a 24hour period

8. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:

This has been brought to the attention of the residents GP and he has amended it to show the maximum daily dose.

This issue was included in a management meeting agenda on the 10th April 2017

Proposed Timescale: Complete

Proposed Timescale: 10/04/2017

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The policy to protect residents from harm or suffering abuse and to respond to

allegations, disclosures and suspicions of abuse was not sufficiently robust to guide and ensure the required details and necessary steps were taken when an allegation or suspicion of abuse is reported.

In addition, the policy did not properly explain the procedures to be put in place to support and protect residents with dementia in the event of an allegation of abuse.

HIQA had not been notified of this allegation within the 3 days notice period required. On review of the policy it was discussed with the registered provider and improvements were required in relation to the policy.

9. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:

The policy on this topic has been up dated and the pathway for notifications has been amended to ensure full compliance.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale: Complete

Proposed Timescale: 10/04/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Gaps were found in how the documents were maintained following an allegation, disclosure and/or suspicions of abuse.

10. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

This policy has been updated to include more robust definitions. The change to the policy will be passed on to the relevant staff in person and via training as scheduled.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale: The policy was updated on the 14th March 2017 and staff are being informed on an on-going basis.

Proposed Timescale: 14/03/2017

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Resident or relative representative forums were infrequent, the minutes of the most recent resident meeting was not available.

Inspectors recommended a review of the current arrangements in place to facilitate residents in each unit.

11. Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:

The frequency of the resident forums has been dictated by the residents themselves. However they can be arranged on an ad hoc basis or the frequency can be changed if they wish. This will be added to the next meeting agenda which is on the 11th April 2017.

I understand that there was some confusion over this as during the inspection inspectors thought that none had been done in 2017. However I can confirm that a satisfaction survey was completed in February of this year and was used in the compilation of the annual quality and safety report.

This will be added to the next resident's forum meeting agenda also and if residents prefer to have separate meetings that will be facilitated.

This issue was included in a management meeting on the 22nd March 2017.

Proposed Timescale:

- The next residents meeting will take place on the 11th April 2017.

Proposed Timescale: 11/04/2017

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Task orientated or neutral care was noted in some observations undertaken such as meal times. At this time, staff were primarily focused on the task of serving, delivering and collecting dishes with little positive or meaningful interaction to enhance the social

occasion for residents. Therefore the meal time experience required improvement as a meaningful activity.

The occupancy of up to 38 residents and day care provision in the dementia specific unit required review in accordance with national and international standards.

Group activity involving up to 21 residents was seen to be interrupted a number of times due to people/visitors and residents entering and leaving the room, and due to the high level of noise being generated in the dementia specific unit.

12. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:

The activity of meal times is always intended to be a social and pleasant one. It is the usual practice for our staff to engage in friendly chat and interactions whilst attending to the work at hand. On the day of the inspection we were surprised to hear the inspectors did not witness this. We are bringing this to the attention of our staff via handovers and will audit same for a period afterwards.

Planned alterations to the home will address some of these concerns as follows;

- There will be a new sitting room which will be domestic in style and ambiance.
- Mobile room dividers which will double up as storage are ordered to create smaller spaces within our large sitting room, but which can be moved back should a larger space be required. These will be low enough so that staff can see over them but tall enough to create areas of smaller, cosier spaces where residents can feel more relaxed.
- We are altering the large sitting room to include an open fire place and shelving which will also help to make the space feel more home like.

The number of residents in the dementia specific unit (DCU) will be reviewed against national and international standards as well as health outcomes.

Group activities will be less likely to be interrupted when the room dividers are in place. We are also looking at ways to notify staff that an activity is underway so that non-essential interruptions do not take place.

However it is important that the residents in this unit are free to move around unrestricted and permitted to join or leave an activity as they wish. Also when people come to visit, it is important to continue to allow a resident to step out of an activity if they wish to join their visitor. Staff will always need to provide assistance to residents as needed in line with their care plan, so some interruptions may still be necessary although we hope to significantly reduce same with the improvements mentioned above.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

- Staff have been reminded of the need to interact throughout their work via daily handovers and at staff meetings. We expect that all staff will have received this

information by the 31st May.

- Alterations to the home (to include the room dividers and fire place and new sitting room) are commencing on Monday the 10th April 2017. We expect all works to the DSU to be completed by the end of July 2017.
- A review will be commenced on the numbers of residents in the DSU and we expect to have this complete by the 31st May 2017.
- A meeting has been arranged with the recreation staff to discuss this issue and we expect to have a plan in place by the 31st May 2017.

Proposed Timescale: 31/07/2017

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Mobile or visual internet communication devices such as an iPad or laptop to facilitate 'skype' or visual and audio communications was not available for use unless brought in by a visitor.

A limited use of pictures and symbols to communicate menu choices, personal and communal rooms was found. This was acknowledged by the provider representative as an area in need of improvement to enhance communication and way finding for residents with dementia.

13. Action Required:

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

Please state the actions you have taken or are planning to take:

Our residents enjoy access to the internet via a portable tablet or via a desktop computer. I regret that not all staff were aware of this but we are addressing this via handovers and public notices.

A review of our way finding signage is under way and where appropriate replacements or additions will be purchased.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

- Notices are in place from the 10th April 2017 and all staff should be made aware via handovers by the 31st May 2017.
- This review is due to be completed on the 15th April and we hope to have all new signage in place by the 31st May 2017.

Proposed Timescale: 31/05/2017

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A record of visitors who were seen entering via a side entry by a coded door for mass was not maintained.

14. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

A permanent visitors log will be placed at the back entrance door.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

30th April 2017

Proposed Timescale: 30/04/2017

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Inspectors recommended a review of the appeal arrangement to provide a more independent review of investigations as the provider representative was actively involved in the governance of the service and the person who staff report to in the person in charge's absence.

15. Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:

A review on this element of the policy will be commenced and where appropriate any changes will be applied going forward.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale: This review will be complete by the 31st May 2017

Proposed Timescale: 31/05/2017

Outcome 05: Suitable Staffing

Theme:

Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A review of the statement of purpose submitted at the time of registration in 2016 with an amended versions submitted in 2017 showed changes in the overall whole time equivalent (WTE) staff provision affecting staff numbers and skill mix.

From a review of the staff roster and discussions with staff, inspectors found that the whole time equivalent staffing levels for nurses and nurse managers had reduced.

16. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

Due to a number of nurses leaving the employment of Laurel Lodge both prior to and since the new provider's arrival to take up jobs in the public sector, and in consideration of the difficulties and time lines involved with recruiting new nurses, one change had to be made in terms of the skill mix of staff in one unit. However the numbers of staff on duty has remained unchanged since the change of provider.

A nursing recruitment drive is well under way with a total of 4.7 WTE's being hired since last August. Once all of these nurses have completed their induction, the skill mix that was in place previously will be reviewed and if considered appropriate will be reinstated.

The Deputy person is in fact 0.6 and not 0.8 which was a typing error. She had requested this change and as soon as possible we replaced the hours that she dropped with a Senior Staff Nurse who has a Masters Degree in Dementia Care, thus protecting the standards of care delivered in the Dementia Specific Unit.

Once all new nurses are in post we will conduct another home wide review to provide further assurance of the correct amounts and skills of staff.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

The review will be complete and any changes required from same in place by 12th May 2017

Proposed Timescale: 12/05/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all staff had completed up-to-date mandatory training.

17. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:

A review of our training matrix is under way to ensure that all staff are captured for evidence of training completed. Where training is required it will be provided as a matter of urgency, subject to staff returning from long term sick leave or maternity leave if that is the case.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale: This work will be complete by 31st May 2017

Proposed Timescale: 31/05/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A review of staff shift patterns is recommended to ensure adequate rest periods were maintained between shifts. For example, a number of staff completed their working shift at 10pm and rostered to return on duty at 8am, within ten hours.

18. Action Required:

Under Regulation 16(2)(c) you are required to: Make copies available to staff of relevant guidance published from time to time by Government or statutory agencies in relation to designated centres for older people.

Please state the actions you have taken or are planning to take:

This review is underway and if required amendments will be applied to our rostering system. The relevant piece of legislation will be made available to staff.

Proposed Timescale: To be complete by the 31st May 2017

Proposed Timescale: 31/05/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Improvement was required to ensure adequate supervision, monitoring and support was in place for staff following an incident such as a medication error.

19. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

The issue in question has been addressed and the member of staff has received updated training in medication management and a program of supervision is underway.

We are also reviewing our HR policy to ensure the staff performance management section is fit for purpose.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

- The nurse received her updated training on the 5th April 2017 following a counselling session on the 8th March 2017.
- Supervision is on-going.

Proposed Timescale: 05/04/2017

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Training records did not identify all staff members that were employed in the centre.

20. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

The training matrix has been updated to include the one person who was not included at the time of the inspection.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale: Complete

Proposed Timescale: 10/04/2017

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Continue with plans to enhance the environment to ensure the design and layout will promote the dignity, well being and independence of residents with a dementia.

21. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:

There are alterations planned to the home which will address these concerns as follows;

- There will be a new sitting room which will be domestic in style and ambiance.
- Mobile room dividers which will double up as storage are ordered to create smaller spaces within our large sitting room, but which can be moved back should a larger space be required. These will be low enough so that staff can see over them but tall enough to create pockets of smaller, cosier spaces where residents can feel more relaxed.
- We are altering the large sitting room to include an open fire place and shelving which will also help to make the space feel more home like.
- We will order new signage

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

- The building works are expected to be complete by the 30th June 2017
- The new room dividers and signage will be in place by the 30th June 2017

Proposed Timescale: 30/06/2017

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Ensure cleaning practices are sufficient, in line with Schedule 6 of the regulations.

Ensure that access to sluice facilities are restricted.

22. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:

Cleaning schedules will be reviewed. New push button locks will be installed on all sluice rooms.

This issue was included in a management meeting on the 10th April 2017.

Proposed Timescale:

- 31st May 2017
- 30th April 2017

Proposed Timescale: 31/05/2017