Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Laurel Lodge Nursing Home
Name of provider:	Templemichael Nursing Home Limited
Address of centre:	Templemichael Glebe, Longford, Longford
Type of inspection:	Unannounced
Date of inspection:	23 June 2021
Centre ID:	OSV-0005394
Fieldwork ID:	MON-0033324

About the designated centre

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

The designated centre providers 24 hour nursing care to 114 residents, male and female, who require long term and short term care (day care, convalescence, rehabilitation and respite). The centre is a two storey building containing three distinct lodges located on the outskirts of Longford town. Glencar Lodge is a 40 bed dementia specific unit. Lissadell Lodge is a 34 bed unit and Hazlewood lodge had 40 beds. The majority of bedrooms have full en-suite facilities. The centre is decorated and furnished to a high standard and a variety of sitting rooms and seated areas, dining rooms in each lodge, a spacious oratory/chapel, a meeting room and hair salon is available for residents use. Well-manicured secure and accessible garden courtyards are available along with a number of other surrounding outdoor planted areas. The centre's philosophy is one of optimization, aimed at facilitating residents to be the best that they can be, promoting independence and autonomy by placing residents at the centre of all decision making within a 'home from home' that is safe, caring and supportive.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	113

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 23 June 2021	09:30hrs to 18:00hrs	Sean Ryan	Lead
Wednesday 23 June 2021	09:30hrs to 18:00hrs	Una Fitzgerald	Support
Wednesday 23 June 2021	09:30hrs to 18:00hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

Residents in Laurel Lodge Nursing Home told inspectors that they were well looked after, received a good standard of care and felt safe. The design and layout suited the residents including access to pleasant secure outdoor areas. The feedback from residents was that they wished to have more consistency in the scheduling of activities, specifically in the afternoon.

This unannounced inspection was carried out during the COVID-19 pandemic. On arrival to the centre, inspectors were met by administration staff who guided inspectors through the centres infection, prevention and control procedure such as temperature checking and hand hygiene.

Following an opening meeting, inspectors were guided on a tour of the centre by the person in charge. It was evident that that the person in charge was well known to residents. From the observations of the inspectors and from conversations with residents, the overall feedback was that the management and staff were kind, caring and respectful and that residents were happy living in the centre.

Inspectors observed that the centre was decorated with features such as antique furniture. At the time of inspection, the centre was undergoing significant building works in the Glencar Lodge, a 40 bedded dementia care facility in the centre. The provider informed inspectors that expansion was occurring to provide ensuite facilities in some of the single rooms. Some works were ongoing while others had been completed.

Inspectors acknowledged that the COVID-19 pandemic had been difficult on residents and staff. Staff and residents spoken to by inspectors detailed the challenges they faced during the pandemic and the structures in place to support one another. Staff described the close relationships formed with residents and their team members and how management had supported them through this difficult time.

Inspectors spent time listening to residents' experience of living through the COVID-19 pandemic and the challenges they faced when visiting and travel restrictions were in place. To date, no resident had tested positive for COVID-19 in the centre. Residents told inspectors that they were supported in maintaining connections with their families through window visits, social medial and telephone calls.

Visiting had resumed indoors in the centre and this was a source of joy for the residents. Two residents told inspectors that they were very fearful of the virus but following full vaccination, they felt their confidence return and looked forward to going out with their families again and having "some normality" in life again.

Residents complimented the staff and management team for keeping them safe. Residents spoke of the close relationship they had built with staff but equally

expressed sadness at the loss of some of these relationships when staff had left the centre to pursue other employment.

Residents were aware of the complaints procedure and would not hesitate to raise a concern with a member of staff should the need arise. The complaints procedure was displayed prominently throughout the centre in an accessible format for residents.

Residents confirmed they could exercise control over how to spend their day and their choice was respected. Inspectors observed the interactions between staff and residents to be respectful, engaging and person centred. Residents had access to daily newspapers and televisions in their bedrooms and communal indoor and outdoor spaces.

Inspectors observed that two of the three lodges had enclosed gardens and residents were observed enjoying this outdoor space. Despite the Level 5 restrictions, residents were facilitated to attend Mass in the centres chapel and the priest continued to attend the centre through out the restrictions. The Mass was also live streamed for residents who wished to view the mass from their bedroom or the dayroom.

Inspectors observed activities occurring in the centre such as singing, playing music and chair exercises. Residents told inspectors that they had attended a live music event in the centres chapel and a harp musician had played a live show for them. This had been scheduled following a recreational therapy staff meeting held in May 2021 where the upcoming activity schedule for residents was planned. There was evidence of past and present activities captured in photographs and displayed throughout the centre.

Some residents wished for more consistent activities to be provided, specifically in the afternoon, and confirmed to inspectors there were some days where there was "little going on". Some residents told inspectors that they would go to their bedroom and knit or read if they did not wish to take part in activities. Healthcare staff who spoke with inspectors confirmed that activities may not be provided every afternoon due to unplanned leave or scheduling of activities coordinators. Healthcare staff informed inspectors that they would endeavour to provide meaningful engagement and activities when these circumstances arose. Inspectors were informed by the person in charge that activities were currently provided 6 days per week, excluding Sunday. Management had identified this shortfall in the provision of activities and were in the advanced stages of recruiting additional activities staff.

Other residents commented that staff worked very hard and they did not like to delay staff because of how busy they were. Similarly, staff confirmed to inspectors that some days were busy and they do not get to spend as much time with residents as they would like to.

Residents complimented the availability and choice of food and snacks. Residents were provided with a choice from the menu and told inspectors that if they did not like what was on the menu they could request something different. A resident guided inspectors to the daily menu on display and detailed how residents

involvement in menu planning was facilitated and that the menu changed monthly.

Residents confirmed that they were consulted about changes in the centre and inspectors viewed minutes of the monthly residents meetings that discussed topics such as visits, activities and the menu. Inspectors viewed surveys completed by residents and their families and the overall results were that residents and their families were satisfied with the service provided.

The following section of this report outlines the inspection findings in relations to the capacity and management in the centre and how this supports the quality and safety of the service being delivered.

Capacity and capability

Improvements were required in the overall governance and management of the centre to ensure there was effective oversight of the service provided. This was an unannounced risk inspection by inspectors of social services to monitor the centres compliance with the regulations.

The findings from this inspection were that the registered provider had breached condition 5 of their registration which is a breach of the Health Act 2007 (as amended). Inspectors observed that a number of structural changes had been made to the centre with some of these changes being re-purposed rooms and newly constructed rooms that were in use prior to being inspected and registered. The registered provider had not submitted an application to vary a condition of their registration to the office of the Chief Inspector. Post inspection, the office of the Chief Inspector had engagement with the registered provider in relation to the alterations made to the centres footprint and a cautionary meeting was held on 02 July 2021. The provider gave a commitment to address this non-compliance and to comply with the regulatory process for future works planned in the centre.

Templemichael Nursing Home Limited is the registered provider of Laurel Lodge Nursing Home. The management team operating the day-to-day running of the centre consisted of a person in charge who was supported on-site by an operations manager and a company representative who is a person participating in the management of the centre. In addition, The person in charge was clinically supported by an assistant director of nursing that deputised in the absence of the person in charge.

The inspection took place during the COVID-19 pandemic. The centre had an up-to-date COVID-19 contingency plan in place that was reviewed by the person in charge.

While there was a defined management structure in place, the management systems required strengthening to ensure that there was sufficient monitoring and oversight of the service provided in areas such as staffing, staff training and

development and record keeping. Further oversight and monitoring of infection control and fire precautions were also required and these are discussed further under the quality and safety section of this report.

The centre is comprised of three distinct lodges. On the day of inspection, there was 113 residents accommodated in the centre. One resident was in hospital. The dependency levels of residents were as follows: 52 maximum dependency, 33 high dependency, 23 medium dependency and 5 low dependency needs.

Each of the three lodges were staffed with a team of nurses, healthcare assistants and clinical nurse manager or senior staff nurse that oversaw the care provided to residents and reported directly to the person in charge. The centre had on-site catering and laundry facilities. There was a team of housekeepers assigned to each unit and a housekeeping supervisor available Monday through to Friday to oversee the cleaning practices and procedures.

Inspectors viewed rosters for the period of 14 June 2021 to 04 July 2021 and observed occasions where the planned staffing levels were not achieved. For example, on the two days prior to the inspection staffing levels in Lissadell lodge were not maintained due to unplanned leave. Furthermore, a review of night time staffing levels was required in this lodge due to the residents dependency needs and layout of the lodge over two floors. Staff informed inspectors that it was not possible to arrange cover as there were no staff available to take on extra shifts. Inspectors observed three occasions where there was one nurse rostered on duty after 4pm until 8pm to provide nursing care to 39 residents with dementia. This was also repeated on the Hazelwood lodge. The was not in line with the nursing staff requirements confirmed to inspectors by the person in charge during the inspection. Inspectors were informed that 21 staff had left employment in the centre since January 2021. Despite the challenges, recruitment was ongoing and the person in charge confirmed that all vacancies had been filled with the exception of one nurse and four healthcare assistants.

Inspectors reviewed five staff files and they were found to contain the information as required by the regulations. Staff had received mandatory training in fire safety, safeguarding, manual handling and infection, prevention and control. Staff were knowledgeable regarding the procedure to take in the event of fire alarm activation, safeguarding of vulnerable people and the procedure to take should a resident or staff be suspected or confirmed with COVID-19. Staff explained the correct procedure to apply and remove personal protective equipment (PPE) and performing of hand hygiene in line with national guidance. However, further analysis of staff training needs was required. Inspectors reviewed the staff training records and observed that 43 staff had not received training specific to dementia awareness and managing behaviours that are challenging. Inspectors brought this to the attention of the management team in the context of the high percent of residents in the centre with a diagnosis of dementia, their higher level of assistance and support needs and that such training would further enhance the support provided to residents.

The records management systems for the effective and efficient monitoring and

management of the service required review to ensure records were available and easily retrievable. Records in relation to the rosters for all staff employed in the centre, staffing strategy, ongoing building works and associated risk management assessments were requested during inspection but were not provided to inspectors for review. This information was requested again after the inspection and some information was submitted for inspectors to review. Information pertaining to a grade 4 pressure wound sustained by a resident in the centre had not been notified to the office of the Chief Inspector as required by regulation.

The complaints procedure was displayed prominently throughout the centre and contained the information required by the regulation. A complaints log was maintained with a record of complaints received, the outcome and the satisfaction level of the complainant. On the day of inspection, inspectors received a complaint regarding missing items of clothing. The complainant had previously raised the complaint with the unit manager but it had not been logged. Inspectors were informed that the delay in recording the complaint was due to being short staffed which delayed the unit manager carrying out administrative duties as they were required to perform caring duties.

The person in charge has completed the annual review of quality and safety of care in the centre for 2020. A quality improvement plan was developed from the analyses of the centres past performance and areas identified for quality improvement included falls and restrictive practices. A resident satisfaction survey had been completed and detailed residents satisfaction with the service provided.

There was a system of auditing in place to monitor the quality of the service provided. This included audits of care plans, restrictive practice, laundry and COVID-19. Some improvement was required to ensure that audits captured all aspects of the service provided and identified areas for improvement such as:

- Hygiene and cleanliness of sluice rooms, storage rooms and laundry facilities.
- practices such as those associated with the inappropriate storage of items in the sluice
- clinical risk areas such as pressure wounds.

The associated action plans for quality improvement were stored on an electronic platform and were not easily accessible for review. Further improvement was required to integrate the action plans into the audit records.

There was evidence of monthly governance and management meetings and inspectors reviewed the minutes of the last meetings dated 31 May 2021. Issues discussed included staffing, risk management, fire precautions and recreational therapy.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider had altered the footprint of the centre and had not made an

application to the Chief Inspector for the variation of a condition applied to the registration of the designated centre.

This included:

- the conversion of existing day room space into a single room with en-suite facilities in the Glencar Lodge.
- the construction of additional day room space in the Glencar Lodge.
- the construction of additional storage space in the Hazelwood Lodge and a consequent reduction in the size of an enclosed courtyard that was not in use by residents.
- the conversion of a single bedroom with en-suite facilities into a double bedroom with en-suite in the Lissadell Lodge.
- the conversion of a double bedroom into a single bedroom with en-suite in the Hazelwood Lodge.

Judgment: Not compliant

Regulation 15: Staffing

Further oversight of the staffing requirements of each individual unit was required to ensure staffing resources were sufficient to deliver person-centred, effective and safe services to all residents.

The rosters evidenced three occasions where one nurse was rostered after 4pm until 8pm to provide nursing care to 39 residents with varying levels of dementia and high support needs. This schedule was not aligned with the required nursing staff levels provided to inspectors by the person in charge during the inspection.

A review of night time staffing levels was required, specific to the Lissadell Lodge, having regard to the dependency needs of the residents and the layout of residents accommodation over two floors. The person in charge confirmed that the staffing levels for this lodge were under review in consultation with the unit manager.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors reviewed the training records and observed that not all staff had received training specific to their role. For example, records highlighted that 43 staff had not completed relevant training to assist them to support residents with dementia and to support residents to manage behavioural and psychological symptoms and signs of dementia.

Judgment: Substantially compliant

Regulation 21: Records

Record-keeping and file management systems required review to ensure records were appropriately maintained, safe and accessible. This was evidenced by:

- the complaint brought to the attention of inspectors had not yet been documented.
- Staffing rosters for all staff employed in the centre were not provided as requested on the day of inspection.
- Information pertaining to the ongoing building works, building method statement and risk assessments had not been made available to inspectors for review.

Inspectors acknowledge that this information was submitted to the office of the Chief Inspector following the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The systems in place to ensure that the registered provider had oversight of the service required improvement to comply with the regulations and to ensure the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by:

- The registered provider was in breach of condition 5 of their registration. This meant that a re-purposed bedroom and newly constructed dayroom and store room were in use prior to being inspected and registered for use by the Chief Inspector.
- Inadequate monitoring of fire safety precautions.
- Inadequate systems of monitoring infection, prevention and control in the centre such as the inappropriate storage of linen and other items in the sluice rooms.
- Further improvements required in the clinical oversight of wound management and statutory notification of pressure wounds.

The management systems in place for risk identification required improvement as evidenced by:

- Risk associated with inadequate oversight and implementation of the colour codes cloth system that posed a risk to infection, prevention and control

practices.

- Inconsistent laundry management system posing a risk to residents' personal property.
- Risk associated with the challenges encountered with recruitment and retention of staff
- the risk associated with insufficient nursing staff available to maintain the planned roster to care for residents with complex care needs.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge was aware of the requirement to submit statutory notifications to the office of the Chief Inspector. However, the Chief Inspector had not been notified of the occurrence of a grade 4 pressure wound sustained by a resident in line with the requirements of Regulation 31.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A detailed complaints procedure was on display throughout the centre and available to residents, relatives and their representatives. Inspectors reviewed the complaints log. The details of the complaints, the actions taken to address the complaint and the complainants satisfaction with the outcome were documented. One complaint had been received in 2021 and this complaint was being managed in line with the centres complaints procedure.

On the day of inspection, a complaint was brought to the attention of inspectors regarding missing items of clothing. The complainant had previously made this complaint to the management but it had not been documented. This is actioned under regulation 21, records.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents received good quality healthcare and support that promoted their independence, autonomy and quality of life.

The management systems in place to monitor, evaluate and improve the service provided required review and strengthening to ensure the systems were effective in identifying deficits and implementing quality improvements to achieve best outcomes for residents. This Included the systems of monitoring:

- Fire precautions
- Infection control
- Personal possessions
- Care planning

The registered provider had upgraded the fire detection system in the centre and had installed fire repeater panels in each of the three lodges. Inspectors were present during a fire alarm activation test and staff were seen to respond and attend to the main fire panel. While all staff had received up to date training on the procedures to take in the event of fire alarm activation, further improvements were required to ensure that the systems in place to monitor and respond to fire risk were robust. This is discussed in detail under regulation 28, fire precautions.

Residents' lives had been significantly impacted by the COVID-19 restrictions. Four staff had tested positive for COVID-19 during the pandemic and no residents had tested positive for COVID-19. Inspectors observed staff practice on the day of inspection and found staff adhered to national guidelines in relation to hand hygiene, maintaining social distancing where possible and in the use personal protective equipment (PPE).

There were some positive Infection prevention and control measures in place including:

- a temperature and COVID-19 symptom check on arrival to the centre and again midway through the day.
- alcohol hand sanitizers were available throughout the centre.
- appropriate signage was in place reminding all persons to complete hand hygiene and observe social distancing when appropriate.

Notwithstanding all the positive measures, inspectors found that the systems for monitoring and implementing cleaning practices and procedures required review. Clinical equipment and bathroom aids were not clean and areas of the building such as sluice rooms, store rooms and laundry rooms were not clean on inspection. Prescribed nutritional supplements were stored on the floor of a store room that also contained linen, clothing and mobility aids.There was evidence of communal use of hoist slings. Further findings are discussed under regulation 27, Infection control.

Residents' bedrooms were personalised with personal possessions of significance to each individual resident. The laundry system and procedure required improvement to ensure that the system in place was consistent to minimised the risk of personal laundry being misplaced or lost. For example, a complaint had been made regarding items of missing clothing. Staff spoken to by inspectors confirmed that items of clothing could be misplaced due to an inconsistent system.

Assessments to identify residents' care needs were undertaken using a variety of

validated assessment tools which informed residents individual care plans. There was evidence of resident and relative involvement in the care planning process. Further improvements were required to ensure that care plans accurately reflected the individual care needs of residents to ensure they were person centred. For example, a sample of residents files reviewed by inspectors showed that a grade 4 pressure ulcer had been diagnosed by a Tissue Viability Nurse. The corresponding care plan was implemented. However, the details of the care plan referred to a sinus wound and not a grade 4 pressure ulcer.

Residents were provided with access to medical services as necessary. Throughout the pandemic, GP's (General Practitioners) continued to have one-to-one on site consultations with residents. Residents were supported to access allied healthcare professionals and expertise including physiotherapy, occupational therapy, speech and language therapy and dietician services.

Visiting had recommenced indoors and residents were receiving visitors in their bedrooms. There was evidence of adequate arrangements in place for consultation with relatives and families during the COVID-19 pandemic.

Despite the challenges specific to the ongoing recruitment of activities coordinators, residents were provided with opportunities to participate in activities. A monthly activities schedule was displayed in each of the three lodges and some residents were actively involved in creating the schedule for activities. Each lodge had a notice board which contained information on activities, advocacy services and range of therapies available in the centre. Details and photographs of the care team on duty were also displayed for residents' information. Staff were knowledgeable about residents likes, past hobbies and interests.

Regulation 11: Visits

Visits were facilitated in line with the current COVID-19 Health Protection Surveillance Centre (HPSC) guidance on visits to long term residential care facilities.

Judgment: Compliant

Regulation 12: Personal possessions

The system in place to manage residents personal laundry required improvement. A consistent approach to the laundry system was not in place which resulted in residents personal laundry being misplaced or lost. Staff confirmed to inspectors that items of clothing being lost or misplaced is an ongoing issue. Inspectors observed that multiple items of clothing in residents bedrooms did not have

identification lables.

Judgment: Substantially compliant

Regulation 27: Infection control

Systems and resources in place for the oversight and review of infection prevention and control practices required an immediate review. Inspectors observed practices that were not consistent with National Standards for infection, prevention and control in the community services. This was evidenced by:

- a color coded cloth mop system was not implemented in full. The system had not been fully implemented to distinguish the colours used for specific areas of the building such as bathrooms and bedrooms.
- some clinical equipment such as bathroom aids and commodes had not been cleaned and were soiled with debris. Many of the wheel castors on commodes were rusted.
- multiple armchairs in the centre were upholstered with fabric. The fabric were worn in parts and not amenable to a cleaning.
- Sluice rooms were multi purpose rooms. Soiled linen was stored in a bag on the floor of one sluice room and there was inappropriate storage of items such as flower vases.
- laundry rooms, store rooms and kitchenettes in each of the lodges were not clean. There was evidence of dust and debris build up in corners, along skirting and behind equipment such as washing machines, sinks and dryers.
- There was areas throughout the building where surfaces were worn, concrete exposed and paint was chipped. For example, the window sill in the Lissadell kitchenette. This meant that these areas were not amenable to effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Not all aspects of this regulation were assessed during inspection.

Inspectors observed the following fire risk areas:

- A newly constructed store room did not contain a smoke sensor. This store room was in use and contained mobility aids and hoist slings.
- Floor plans displayed in the Glencar lodge require updating to include the newly constructed sections of building. For example, the addition of a snooze room to the main day room had not been updated on the floor plans

displayed in the centre.

- Inspectors were not assured that the largest compartment could be safely evacuated as the person in charge confirmed on the day of inspection that a fire drill evacuation of the largest compartment simulating night time staffing levels had not been completed.
- On the day of inspection, inspectors observed fire doors were wedged open with chairs which prevented the closure of the fire doors when the fire alarm activated. This compromised the purpose and function of the fire door in protecting residents, visitors and staff in the event of a fire.

Assurances are required in the following risk areas:

- the L1 fire alarm system has been updated to reflect the changes to the layout of the centre and accurately identifies the exact location of each room fire sensor in the event of a fire and every room requiring a fire sensor is fitted with one. For example, the newly constructed store room.
- A fire door assessment is required by a competent person regarding the likely fire performance of a cross corridor door in Glencar Lodge.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Some improvements were required to ensure that each residents' care plan accurately reflected the assessment of their needs and is person centred in its detail.

This was evidenced by:

- A grade 4 pressure ulcer had been diagnosed by a Tissue Viability Nurse. The corresponding care plan was implemented. However, the details of the care plan referred to a sinus wound and not a grade 4 pressure ulcer.
- A care plan had not been updated to reflect the identified changes in the continence care needs of a resident that required a urinary catheter.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to timely referral and review of medical and allied health professional care and expertise as appropriate. Residents had access to a general practitioner (GP) throughout the national COVID-19 pandemic. The resuscitation status of residents was clearly documented in residents records.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were supported and protected. Staff were observed to respect residents autonomy, privacy and dignity. Residents had control over their daily lives and could exercise choice in how to spend their day.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Laurel Lodge Nursing Home OSV-0005394

Inspection ID: MON-0033324

Date of inspection: 23/06/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: The Registered Provider will ensure through the Registered Provider Representative and Person in Charge that all aspects of the Health Act 2007 Regulation 7. 'Applications by registered providers for the variation or removal of conditions of registration' are complied with in full. This will be achieved by applying under section 52 of the Act for the variation or removal of any and all conditions of registration in an application in the form determined by the chief inspector.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: We will continue to recruit to fill all vacant positions amongst Care Staff and Nursing Staff and increase our Recreational Therapy Staff contingent until we have achieved our Statement of Purpose whole time equivalent for both Nursing Assistant's and Staff Nurses and are able to ensure all rostered shifts are covered in all eventualities. Where there is an unforeseen and unpredictable staff loss we will ensure that there is are system in place for access to adequate additional staffing beyond our own internal degree of flexibility by ensuring we have sufficient external Agency Contacts available to ensure continuity of staffing at all levels. Flexible use of our own staff will still be our first choice. We will introduce an additional WTE member of night care staff to the Lissadell Lodge	

roster, where the historical floater between Glencar and Lissadell had been switched in favor of an extended day shift to incorporate one member of staff commencing at 6am rather than 8am. This will represent an addition of 56 carer hours per week. The Recreational Therapy Contingent has already been increased from 1.92 to 3.48 WTE.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development: Our Training and development matrix has been and will continue to be enhanced by the provision of further dementia specific training. Training in dementia care did take place on Tue 1st, 8th, and 22nd July 2021.The training matrix will continue to be closely reviewed by the Operations Manager and Person in Charge with particular reference to the appraisals of all staff where training needs are highlighted and the continued use of training audits to ensure all pertinent areas are catered for above and beyond the mandatory training.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records: A review of the records kept within the centre has been completed. Management have committed to ensure all complaints are logged on the day of the complaint to avoid any future delay. The Person in Charge will ensure the complaints process is Audited at the end of August 2021 to ensure this is embedded.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The governance structure in relation to Regulation 23 will be enhanced by an increase in the frequency and level of reporting to the Person in Charge and Registered Provider representative from the individual areas within the home. There will be more frequent

auditing and feedback with regards to the cleaning matrix which will include a weekly audit of cleanliness across the three units and the communal areas. The cleaning staff will use the colour coding provided on the present mops by removing the colour tags which are not appropriate and segregating the mopheads by use. This system will then be reviewed at the end of August to determine it's effectiveness.
The audit of fire precautions will be increased to a monthly audit and any non-compliances will be raised through the weekly management meeting and escalated accordingly. A system of monthly checks on residents clothing and possessions will be reinforced and audited through the electronic system to ensure compliance where any non-compliance is found. This will be fed back and documented through the weekly management meeting and escalated to the monthly management oversight meeting where any area remains unresolved or weak.
Care staff have been allocated to each resident as a key worker to take responsibility for those individuals' possessions and management will write to families to make them aware of the importance of logging any new clothes or possessions with the staff prior to adding them to the residents existing possessions in order that they can be logged and this can be checked through audit.
The Unit managers will carry out monthly rather than quarterly care plan audits and the unit manager will not audit their own care plans with each unit manager auditing other units. The care plans to be reviewed will be decided by senior management each month and fed back through the monthly management oversight meeting.
Risk assessments will be carried out or reviewed for all the areas mentioned above as well as a review of staffing levels to ensure improvements can be maintained.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge will carry out a review of Notifications and the Notification History within the HIQA Portal. The unit managers will now feedback all relevant data weekly rather than monthly with a history of each week recorded. All the indicators collected which include all the areas of notification as required by Regulation 31 will then be reviewed to ensure nothing has been missed in the notification process.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Care staff have been allocated to each resident as a key worker to take responsibility for

those individuals' possessions and management will write to families to make them aware of the importance of logging any new clothes or possessions with the staff prior to adding them to the residents existing possessions to ensure they can be logged. This can be checked / vertified through audit. Their will be a review of the current pigeon hole system for clothing return and a log made by the laundry workers of any anomalies, such as clothing which is found without a tag in place or which is not listed on the resident's possession list. A work schedule will be complete whereby resident's key workers will check and sign off on their residents' clothes confirming same have been fully labelled.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Staff have all completed advanced training as mandatory on infection control to include the correct use of PPE & Breaking the Chain of Infection. We have a thorough and up to date COVID Plan and policy in place which includes a cleaning Matrix which has been reviewed from a COVID 19 perspective. We will carry out a full review of the storage of items, ensuring the sluices become single purpose and any equipment which is rusted or damaged to the degree that it poses an increased risk to infection prevention and control will be disposed of. All the commodes which had rusted wheels or wheel covers have already been disposed of. A new matrix is to be completed which ensures sign off on the cleaning of all areas of the home. A maintenance survey of the Nursing Home will be completed by the end of August to formulate a renewed plan of upkeep to ensure items such as chipped or worn surfaces are addressed fully.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The largest compartment in the building at the time of the inspection was upstairs in Lissadell with 8 residents occupying 7 rooms. This compartment will now be used as the main area for evacuation simulation drills. Since the inspection a new fully compliant and certified fire door has been professionally fitted in Glencar Lodge reducing the size of their largest compartment. The nursing home is now fully connected to the fire panel including all new rooms awaiting approval for use. Management are carrying out documented checks four times per day at present to ensure the practice of placing chairs where they could potentially block an auto closing fire door is removed entirely.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

The Unit managers will carry out once monthly care plan audits via the electronic system which is an increase from quarterly audits and have been instructed to audit each other's units to avoid any possibility of bias. The care plans to be reviewed will be decided by senior management each month and fed back through the monthly management oversight meeting. The list of mandatory care plans has been reviewed and discussed at the management meeting which took place on 28th June 2021. Each resident will have their care plan commenced on admission with mandatory care plans completed within 72 hours and will then expand as our knowledge of the resident develops further. Senior management will check each new resident at day four post admission to ensure the above has been fully complied with. In addition the monthly audit will look at quality of care planning and ensure care plans are person centred.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 7 (1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition or conditions of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	27/07/2021
Registration Regulation 7 (2)	An application under section 52 of the Act must specify the following: (a) the condition to which the application refers and whether the application is for the variation or the removal of the condition or conditions; (b) where the	Not Compliant	Orange	27/07/2021

	application is for the variation of a condition or conditions, the variation sought and the reason or reasons for the proposed variation; (c) where the application is for the removal of a condition or conditions, the reason or reasons for the proposed removal; (d) changes proposed in relation to the designated centre as a consequence of the variation or removal of a condition or conditions, including: (i) structural changes to the premises that are used as a designated centre; (ii) additional staff, facilities or equipment; and (iii) changes to the management of the centre that the registered provider believes are required to carry the proposed changes into effect.			
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her	Substantially Compliant	Yellow	31/08/2021

	personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/08/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	27/07/2021
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	27/07/2021
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	27/07/2021
Regulation 23(c)	The registered provider shall ensure that management	Not Compliant	Orange	31/08/2021

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	27/07/2021
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	19/08/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	27/07/2021
Regulation 28(3)	The person in	Not Compliant	Orange	27/07/2021

	charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	31/08/2021
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant		27/07/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant		27/07/2021