

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | Lucan Lodge Nursing Home |
| Centre ID: | OSV-0000061 |
| Centre address: | Ardeevin Drive, Lucan, Co. Dublin. |
| Telephone number: | 01 628 0555 |
| Email address: | tanya@lucanlodge.com |
| Type of centre: | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| Registered provider: | Lucan Lodge Nursing Home Limited |
| Provider Nominee: | Tanya Patterson |
| Lead inspector: | Deirdre Byrne |
| Support inspector(s): | Shane Walsh |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 70 |
| Number of vacancies on the date of inspection: | 4 |

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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 Quality 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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 17 August 2016 07:30 To: 17 August 2016 19:00

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

| Outcome | Our Judgment |
|---|--------------------------|
| Outcome 02: Governance and Management | Non Compliant - Major |
| Outcome 04: Suitable Person in Charge | Compliant |
| Outcome 07: Safeguarding and Safety | Compliant |
| Outcome 08: Health and Safety and Risk Management | Non Compliant - Moderate |
| Outcome 09: Medication Management | Substantially Compliant |
| Outcome 10: Notification of Incidents | Compliant |
| Outcome 11: Health and Social Care Needs | Compliant |
| Outcome 12: Safe and Suitable Premises | Substantially Compliant |
| Outcome 13: Complaints procedures | Compliant |
| Outcome 15: Food and Nutrition | Non Compliant - Moderate |
| Outcome 16: Residents' Rights, Dignity and Consultation | Compliant |
| Outcome 18: Suitable Staffing | Substantially Compliant |

Summary of findings from this inspection

This was an unannounced monitoring inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland. It also followed up on matters arising from a dementia care thematic inspection carried out on 26 April 2016, and to monitor progress on the two major non-compliances found at that inspection. A meeting was held on the 18 May 2016 with the provider to discuss those non compliances and the action to be taken.

As part of this inspection, the inspectors met with residents, relatives and staff members, observed practices and reviewed documentation such as policies and procedures, care plans, medical records and risk management processes.

Inspectors identified a number of new areas that required action to be taken during the inspection. The arrangements in place to review the fire safety precautions and the maintenance of service records of firefighting equipment required improvement. The provider took action to address this before the end of the inspection, and submitted information to HIQA after the inspection. The systems in place to ensure residents received meals in accordance with their assessed needs also required improvement.

Inspectors found that progress had taken place since the last inspection. There were revised systems in place to monitor residents with diabetes and persons who had lost significant weight. The medicine management policies and procedures were found to be implemented in practice by staff. Residents' verbal complaints were recorded and investigated, and there was good access to independent advocacy services.

There was further improvement required to ensure an adequate staff skill mix in the centre at night to meet the residents' assessed healthcare needs. It is acknowledged that the provider has been recruiting new nursing staff since the last inspection. Overall, inspectors found that residents expressed satisfaction with the care and supports available to them.

A total of 12 outcomes were inspected and six outcomes were in full compliance. There was substantial compliance in relation to three outcomes: medicine management, premises and workforce. There was one major non compliance in outcome two. There were moderate non compliances identified relating to two outcomes: risk management and food and nutrition.

The 20 actions from the previous inspection were followed up. 17 actions were fully addressed. One was in progress, and two were not fully addressed, this is discussed the body of the report.

There are eight actions required from this inspection. The action plan at the end of this report identifies the actions where improvements must be made to meet the requirements of the regulation and the national standards. Sustained improvements are required in respect of the non compliances found at the previous inspection.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There were systems in place to continuously review of the quality and safety of life of residents. However, some improvements in this process were identified. There was no annual report completed as per required by the regulations. There was one action from the thematic inspection in April 2016 followed up and it was still work in progress. The action was: the management systems in the centre did not ensure residents' needs were consistently and effectively monitored and require improvement.

The provider had ensured systems were in place to monitor the quality and safety of care. However, there were areas of non compliance identified during the inspection that had not been picked up on during the audit process, therefore the system required improvement. For example, the audit on nutrition did not identify the issues around supervision of residents who require modified diets and offering choice at mealtimes to all residents irrespective of their diet. There was progress made to address the action from the last inspection in the completion and review of audits. A schedule of audits for 2016 was in place and their completion was overseen by the person in charge and clinical nurse manager. A range of audits were carried out. Inspectors read audits covering areas such as medicine management, care plan and assessment, nutrition care plans and diabetes care. There were detailed findings, conclusions and action plans developed, with an overall score given. Audits were completed every six month, or if improvements were identified, within one month to three months if they failed to reach a minimum level. The audits were discussed at the clinical governance meetings.

The person in charge gathered key performance indicators (KPIs) from each of the three floors on a weekly basis. The KPIs pressure sores, wounds, falls, significant weight loss, significant events, use of restraint, nutrition and new admission. The person in charge summarised the information in report which were then discussed at a weekly. Where

clinical risks were identified, these were escalated and records maintained of the action to be taken. The weekly report was also issued to all nursing staff in the centre. Every three months the person in charge completed a review of all KPIs and devised an action plan for each.

The registered provider of the designated centre is Lucan Lodge Nursing Home Limited. The person nominated to represent the provider (the provider) was based at the centre also. The person in charge met the provider on a regular basis. It was noted there was no formal senior management meetings in relation to the governance and operation of the centre. The provider said she attended a range of meetings regarding health and safety and clinical governance on a regular basis.

An annual report on the overall review of the safety and quality of care of residents has not been completed. This was discussed with the provider who informed inspectors that the review would be completed by September 2016 and that same would be submitted to HIQA.

The findings on this inspection in respect of outcome 8, 15, and 18 evidence that sustained improvement in the governance in the centre is required.

Judgment:
Non Compliant - Major

Outcome 04: Suitable Person in Charge

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

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that the centre was managed full time by a registered nurse with experience in the care of older people.

The person in charge was familiar with the residents' health and social care needs. She is a suitably qualified and experienced manager of the centre having been the person in charge for a number of years.

The person in charge has post registration qualifications in care of older people and in management. She has also continued her own professional development and has attended in-house training and all mandatory training areas.

Residents told inspectors they were familiar with the person in charge who regularly met

with them, and she was observed to stop and talk to residents also.

She was supported in her role by a clinical nurse manager (CNM) who deputised in her absence.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There were systems in place to protect residents from being harmed or suffering abuse. There were measures to ensure a positive approach to manage expressive behaviours. Where restrictive practices were carried out, these were done in accordance with the regulations and national policy. The action from the dementia care thematic inspection in April 2016 was followed up and addressed.

The action related to:

-The implementation of the National Policy "Towards a restraint free environment" requires improvement.

-The alternatives to the use of restraint were not considered and recorded on residents' files.

-There was lack of clear consultation with residents' in the use of restraint.

Since the last inspection, the provider had taken a proactive approach to in the implementation of the National Policy "Towards of Restraint Free Environment in Nursing Home". There had been a reduction in residents using bedrails from 16 to 8 residents. The person in charge said she reviewed bed rail usage and encouraged residents to remove bedrails. The provider had invested in a number of new low low style beds. There were no residents using lap-belts in the centre. Four residents had required the use of chemical restraint in the previous months, but this was related to managing anxiety and not to manage behaviours.

A centre specific policy on the use restrictive practices was read by inspectors and seen to be implemented in practice. Where restrictive practices were in place, care plans were developed, and documented checks carried out every two hours when in use. There was documented evidence on residents' files of their consent or consultation with families in their use, also an action at the previous inspection and addressed.

There was a policy on the protection of vulnerable adults, which referenced the Health Service Executive (HSE) Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. The policy included information on the different types of abuse, the reporting arrangements and the procedures to investigate an allegation of abuse. Records read confirmed all staff had received training in the prevention of abuse. The training was facilitated by the CNM in the centre. An outline of what the training entailed had not been developed and this was discussed with the person in charge who said this would be addressed. Inspector spoke to staff during the inspection who were knowledgeable of the types of abuse and the reporting arrangements in place.

Inspectors reviewed the systems in place for safeguarding residents' money and found evidence of good practice. A robust system of documentation was in place to monitor and record all transactions which were accompanied by two staff signatures.

There had been no allegations of abuse notified to HIQA since the last inspection. The person in charge was aware of the requirement to notify any such allegation to HIQA. This is further discussed under Outcome 10 (notifications). Residents told inspectors that they felt safe living in the centre.

There was a secure entrance to the centre. There was no receptionist during the day but staff and residents used a key padded code to enter and leave the building.

Inspectors read a policy on the management of responsive behaviours which guided staff practice. At the time of inspection a small number of residents presented with expressive behaviours. There were regular assessments completed for the residents and care plans were developed to guide the practice to be delivered. A sample of care plans read outlined the type of the behaviours, the triggers and the actions to take to mitigate the behaviours. Staff informed the inspector how to handle certain situations with residents. There was access to psychiatry and psychology services if required.

Judgment:
Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found there were arrangements in place for reviewing the precautions in place to prevent and control the spread of fire however, the availability of certificates of service for the emergency lighting required improvement.

There were arrangements in place for maintaining of the fire fighting equipment. However, the systems in place for servicing the emergency lighting required improvements. While there were records of checks of emergency lighting, a certificate confirming the maintenance of emergency lighting on a quarterly basis had not been provided. Inspectors read certificates that confirmed the fire extinguisher was serviced on an annual basis and the fire alarm system had been serviced every quarter.

The centre was compartmentalised with fire doors, all of which were on electromagnetic or 'free-swing' self closing mechanisms which would close the doors in the instance of the fire alarm sounding. Emergency exits were un-obstructed and emergency exit signs were prominently displayed.

Inspectors reviewed a fire safety management policy for the centre. The provider was requested to review the policy and subsequently submitted a revised version to HIQA.

There were fire safety procedures displayed throughout centre. The procedures did not reflect the procedures to be followed in the actual event of the fire alarm being activated in the event of a fire. When this was brought to the attention of the person in charge and the provider, inspectors were shown detailed day and night procedures to guide staff. These were given to each staff on their first day. The provider informed inspectors that the procedures would be displayed at the nurses' station for all staff to see.

There were measures in place to ensure staff were knowledgeable of the fire procedures to follow in the event of a fire. Staff spoken to were familiar with the procedures in place and had all received training. A staff member had been trained up as a train the trainer to give fire safety training to staff. The staff member was met at the previous inspection and had outlined their role. There was evidence of regular training for all staff on an annual basis. This was confirmed from a review of training records.

There were regular fire drills taking place in the centre. The drills took place at different times of the day to capture staff working day and night shifts. This was confirmed by staff working day and night shifts also. Records of drills were read and included the length of time, the staff in attendance and any follow up action required.

There was a risk management policy in place that met the requirements of the regulations. There was a risk register for the centre. Where risks were identified, they were evaluated, controls were put in place for mitigation and risks were then re-evaluated. Risk assessments within residents' individual files were updated every four months.

Many residents were observed to be actively mobile and moving throughout the centre as they wished. Residents that needed some assistance with their mobility were seen to

be assisted by staff. Handrails were located throughout the centre and all floor coverings were undamaged and free from trip hazards. All staff had training in manual handling.

There were procedures in place for infection control in the centre. Hand gel dispensers were located regular intervals throughout the corridors. Personal protective equipment such as disposable latex gloves and disposable aprons were available throughout the centre. Inspectors spoke with staff who seemed to be knowledgeable around the precautions to be taken if there was an outbreak of an infectious disease. Cleaning staff were observed to be following best practice around the prevention and control of healthcare associated infections.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The residents were protected by the centre's policies and procedures for medicine management. There was an area of improvement identified in relation to the administration records and storage of temperature controlled medicines. The action from the inspection in April 2016 was found to be completed.

Inspectors observed the administration of residents' medicines in the morning on one unit and they appeared to be in accordance with the time prescribed by the medical practitioner. A sample of completed prescription and administration records were reviewed with a nursing staff. Overall, there was evidence that medicines were administered at the time prescribed. However, the layout of the administration record sheets required improvement. For example, some sheets did not state the times medicines were to be administered and instead stated breakfast, dinner or lunch. Therefore it could not be consistently clarified what time medicines were administered at. This was discussed with the person in charge and the provider at feedback who assured inspectors the administration sheets will be revised and replaced.

There was a medicine policy which guided practice and nursing staff were knowledgeable of the policy and professional guidelines. Staff nurses involved in the administration of medicines had all completed training and since the last inspection from the pharmacy service. The nurses were now required to complete competency assessments which the pharmacy service would also carry out.

The medicines in the centres were securely stored, with an improvement found in relation to the storage of temperature controlled medicines. For example, on one floor, temperature controlled medicines were stored in a refrigerator in a locked kitchenette but the room could be accessed by all staff and the refrigerator was not locked. This was brought to attention of the person in charge who said that action would be taken to address this. The temperature was monitored and checked daily by the nursing staff, and record of the check maintained. Inspectors found the temperatures were within acceptable standard limits.

There was a nurse signature list. It contained signatures of the nursing staff working in the centre.

There were regular three-monthly reviews of residents' medicines were carried out. The general practitioner (GP) and the pharmacist were involved in the review, and a review form was completed for each resident. The CNM coordinated the dates of reviews.

Where medicine errors occurred in the centre, incident forms would be completed and investigations carried out by the person in charge. There had been no medicine errors or near misses in the centre since the last inspection.

Medicines that required strict control measures (MDAs) were reviewed at the previous inspection in April 2016 and practice was found to be in line with professional guidelines was found at that time.

There was evidence of detailed and regular medicine audits carried out. The person in charge completed audits every six months or more frequently if required. The pharmacy service completed monthly audits.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
A record of all incidents within the centre was maintained and no incident as listed in schedule 4 of the regulations was required to be notified to HIQA since the last inspection. The centre had submitted a report to HIQA every quarter detailing all other incidents that occurred in the centre.

No notifiable events had occurred within the centre since the last inspection in April 2016. The action from the thematic inspection in April 2016 was also followed up and addressed.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs

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

Theme:
Effective care and support

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There was evidence that residents' healthcare needs were met to a good standard, with the provision of evidenced based care in the line with the centre's policies and procedures. Inspectors found the provider had addressed the actions from the thematic inspection in April 2016.

The actions that were followed up:

1. There was inconsistent evidence of admission assessments on residents' files.
2. The care plans for some residents did not fully guide practice. For example, weight loss and diabetes management.
3. A high standard of nursing care was not provided to residents in the management of diabetes and medicine management.
4. There was no copy maintained of a transfer letter when residents were temporarily admitted to an acute hospital.

There were good practices evident in the care of residents with diabetes. This was an action at the previous inspection and it was fully addressed. A diabetes policy had been developed since the last inspection. It was a comprehensive document that provided detailed guidance to staff on the care to be provided to people with diabetes. There were currently 12 residents with a diabetes diagnosis living in the centre. All residents had been reviewed by their GP since the previous inspection in April 2016. Three residents' files were reviewed by inspector. There were detailed care plans developed, that provided clear advice and also incorporated diabetic foot care for the prevention of ulcers.

There was evidence of regular monitoring of residents' blood sugar levels. Each resident had their own blood glucose meter, which was name tagged and securely stored at the nurses' station in the medicine trolley. The nurses were familiar with each resident discussed and showed inspectors the blood sugar meters. There were regular and up-to-date records of each resident's blood sugar checks. To ensure there were no gaps in checks, nursing staff gave an update at handover, of any resident overdue to have their blood sugar level taken. Where residents had refused aspects of the treatment, this was recorded and respected. The resident's GP was also informed and if required, the resident was regularly reviewed. Since the last inspection all nursing staff had completed training in diabetes care. Inspectors found staff spoken to were familiar with the diabetes care to be provided to residents.

Inspectors reviewed the arrangements in place to monitor and respond to weight loss. There was a nutrition management policy in place. However, the implementation of the measures in place for residents at risk of malnutrition required improvement. For example, the implementation of care plans for residents specific to the provision of prescribed meals plans required improvement. This is outlined in Outcome 15 (food nutrition)

There was evidence of improved practices in responding to residents' who had experienced weight loss at this inspection. Residents' weights were recorded and their nutritional needs were assessed every month using a malnutrition universal score tool (MUST). Depending of the nutritional assessment further action would be taken. For example, three day food charts would be commenced and the resident's weights would be monitored weekly or fortnightly. There were criteria in for referring residents to a dietician. This was an action at the previous inspection and addressed. A number of residents who had experienced significant weight loss had care plans developed which referenced the dietician recommendations such as fortifying meals, encouraging regular snacks, weekly monitoring of the resident's weight.

Residents' files were in electronic format. There were comprehensive nursing assessments and additional clinical risk assessments completed every four months. There were care plans devised where risks were identified. The care plans reviewed were comprehensive, detailed and guided practice in the areas for care to be delivered. This was an action from the previous inspection and fully completed. There was evidence of resident and relative involvement in the development and review of the care plans.

The actions from the previous inspection regarding admission assessments and transfer letters had been addressed. There was a summary of each resident's admission assessment also provided alongside residents' records. A transfer letter was saved onto each resident's file. A nurse explained that the information in the letter would be updated and printed off if resident was to be transferred to hospital. A copy would be also held electronically on the resident's file. There were nursing progresses recorded in line with professional guidelines.

There were audits completed on care plans and assessments to ensure they were in compliance with the regulations. In addition, audits were also read on diabetes care and

nutrition care plans. The audits were analysed and used to inform practice and were reviewed by the person in charge. They were completed at a minimum every six months.

Residents had good access to GP services. The residents could also choose to retain the services of their own GP if they wished. There was good access to allied health services also. A physiotherapist and an occupational therapy (OT) worked part time hours in the centre. There was also access externally to speech and language therapy (SALT) and dietetic services. Chiropody, dental and optical services were also provided. There was also access to psychiatry of older age. Inspectors reviewed residents' records and found referrals were made to these services and results of appointments were written up in file notes.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The design and layout of the centre was in line with the statement of purpose. Inspectors reviewed the actions from the thematic inspection in April 2016 which were as follows:

1. The natural light to the lower ground floor bedrooms and dining rooms is blocked by an external wall.
2. A four bedded room in the centre will not meet the National Standards.
3. The use of best practice design dementia care facilities should be further explored to meet the needs of all residents' in the centre.

The action regarding the wall blocking the natural light into the rooms on the lower ground floor has not yet been addressed. The provider's action plan response has given a timeframe of 31 December 2017 to address the matter.

The action regarding the four bedded room is no longer applicable since the amendment to Schedule 6 the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016. This bedroom met the residents' individual needs on the day of the inspection. There was a screen around each bed to ensure residents' privacy, and each resident had a locker and a chair by their bed. This will be reviewed at each inspection.

The provider had made good progress to enhance the design and layout of the centre to meet the needs of residents with a dementia diagnosis. Parts of the centre had been further enhanced using best practice design for dementia care facilities. The lower ground floor had been further improved as follows:

- bedroom doors were all painted a bright colours, which changed depending on the corridor,
- increased and accessible signage for residents to way find for example, the toilet and the garden,
- all bedroom doors were personalised with photos and colourful name tags to help residents identify their bedroom,
- lots of interesting points of interest in the communal areas such as plants, coats on hangers, rummage boxes, wall murals and pictures were provided.

The provider acknowledged work remained to be done in some areas. It was observed, for example, that colour contrasting in communal bathrooms had not been fully considered. Most of the colour used was white. The use of contrasting colours on toilet fixture and fittings such as seat covers and hand rails may further enhance residents with a dementia in independently using these toilets.

A safe and suitable garden was located off the lower ground floor. It was accessible to all residents. The door was locked at night time in the interests of residents' safety but it was unlocked again in the morning time. Any resident who approached the door was not restricted from opening it to go into the garden. This was an action at the previous inspection and fully addressed. Some residents told inspectors they enjoyed going into the garden, and it was reported that residents on the lower ground floor had their lunch outside in the garden in recent days. Due to heavy rain during the inspection no-one was using the garden.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors found that there were policies and procedures in place for the management of complaints. The actions from the thematic inspection in April 2016 were followed up on during this inspection and they had been satisfactorily implemented.

A complaints procedure was prominently displayed in a number of areas throughout the centre. The procedure and complaints policy had been amended since the last inspection and it was found that the information in the procedure was in line with the information in the policy. The complaints process was found to be user-friendly and accessible to residents. There was a clearly outlined person nominated to deal with complaints. An appeals process was in place and there was a person nominated to deal with appeals.

Inspectors were informed that verbal complaints were now being recorded at each floor level. Each floor had a local complaints book in which verbal complaints were being recorded by staff. The person in charge maintained a folder in which the outcome of the complaint and satisfaction of the complainant was recorded. The person in charge informed the inspectors that complaints were reviewed each week during the weekly audit in order to track and trend complaints.

The inspectors found that all complaints had been addressed and appropriate action had taken place.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The actions from the inspection in April 2016 were followed up under this outcome. Inspectors noted that not all actions had been met/completed. While there had been some improvement since the last inspection, not all residents were being provided with a choice at meal times. Also, some residents did not receive meals in accordance with their assessed nutritional needs and care plan.

Inspectors observed mealtimes in the centre. Meals were provided on all three floors and on each floor they were observed to be a social and relaxed occasion. A number of residents informed the inspectors that the food available in the centre was delicious and excellent. Inspectors spoke to the chef and found that the food was prepared and cooked correctly. Menus were displayed on each floor.

Healthcare staff were responsible for serving the meals to residents and assisting residents to eat if needed. Residents that required assistance at meal times were observed to be supported by staff in a discreet and sensitive manner.

Healthcare staff were also responsible for modifying the texture of residents meals and fortifying meals for residents' at risk of weight loss. However, inspectors did not observe this happening in practice. For example:

1. two residents did not receive their meals in the correct modified consistency as outlined in individual care plans. This was brought to a nurse's attention who was required to take immediate action.
2. Some residents who had experienced weight loss did not have their meals fortified, as per their care plan. This was also brought to the attention of the person in charge during the inspection.

There was a lack of supervision of mealtimes by the nursing staff to supervise health care staff and ensure residents received the correct diet as per their assessed needs. Since the inspection in April 2016 residents on a liquidised diet now had a daily choice of up to eight options from a separate menu however, residents on any other modified diet, such as minced or moist, were only provided with one option at meal times. It was noted that there was a wide variety of choice of regular meals available at each mealtime.

Inspectors were informed that refreshments and snacks were available to residents for example, fruit, biscuits and tea/coffee were available at all times in the centre. There were sandwiches, buns and cakes prepared and left in the fridges at each floor level in the evening if residents wished to have a late snack also.

Judgment:

Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors found the provider consulted with residents and they participated in the organisation of the centre, and residents were enabled to exercise choice and control over their life. The actions from the previous inspection were addressed.

The actions from the thematic inspection in April 2016 were as follows:

1. The provision of meaningful activities for residents with a dementia and who were unable to take part in activities, required improvement.
2. Information on independent advocacy services was not up-to-date or demonstrated to be offered to residents.
3. The regularity of resident meetings in the lower ground floor unit requires review.

Since the last inspection the provider had reviewed activities carried out in the centre. The occupational therapist had reviewed the activities programme. Residents had a social care assessment completed every four months and a care plan was developed that outlined their likes and interests. The residents in lower ground floor which accommodated residents' with a dementia diagnosis had a set programme of activities, but these were carried out in accordance with residents' wishes during the day. The activities carried out were observed to be mainly one to one time completed by the care or nursing staff. There was plenty of meaningful interactions observed with the residents, many of whom could not, due to their dementia, participate in big group activities.

The activities observed included hand massage, hair treatment, singing, quizzes and exercises. The staff were observed to sit alongside residents, and engage in a meaningful way with them. For example, asking questions, responding to their questions, gently teasing and laughing. The residents appeared to be enjoying many of the interactions or just observing the activities going on. At any one time there was always a staff member supervising the sitting room where residents sat during the day.

Residents had access to an advocacy service and there was contact information for an independent advocacy service displayed on residents' notice board in the centre. A representative from the advocacy service had been visited the centre since the last inspection. A number of residents individually met the representative, and this was confirmed by residents who spoke to inspectors. The person in charge said the visits were private but as a result of them they were enhancing these residents ability to maximise their right to independence and choice.

There were systems in place to consult with residents. There was a residents' committee that met on a regular basis. The minutes of the last meeting was read . The issues brought up were mainly in relation to meals and individual matters. There was evidence

that the person in charge had followed up on issues raised at the meetings. Since the last inspection, the provider had requested that the advocacy service representative visit the residents living in the dementia focused unit on the lower ground floor. The representative of the advocacy service would facilitate the resident committee meetings going forward, and residents from the lower ground floor would be included in these meetings also. This was an action at the previous inspection and addressed.

Judgment:
Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found the staff skill mix to meet the assessed healthcare needs of residents during the day continued to be work in progress. The actions from the thematic inspection in April 2016 were also followed up:

1. There was an inadequate number of nurses to meet residents' assessed needs of care at night time.
2. Nursing staff did not have appropriate training for the care of residents' with diabetes.
3. There was no system of staff supervision in the centre.

On the day of the inspection there were 70 residents accommodated in the centre. Over 50% of the residents had a high to maximum dependency level, and 80% of all residents had a dementia or a cognitive impairment diagnosis. The staff skill mix in the centre at night time continued to require improvement. In conversation with the person in charge and from a review of the staff rota, on some nights of the week there were three nurses assigned to work from 8pm to 8am. A CNM worked nights, which enhanced management of the centre at these times.

There was a recruitment process in operation with five additional nursing staff hired. Some of these were in process of obtaining their registration personal identification numbers. The nursing staff skill mix both at day and night time requires constant review to ensure they meet the assessed needs of the residents.

During the day there were three nurses on duty from 8am to 8pm, along with 17 health care staff, which decreased to 16 health care staff in the evening. To ensure continuity of care for the residents the same staff were rostered on each floor. The system of supervision was discussed with the person in charge. To enhance the supervision of staff and residents on each floor, a new clinical nurse manager had been recently recruited. There was now a CNM over each floor, which would enhance the governance at floor level also. The person in charge was supernumery in her role, along with a CNM.

There was evidence that staff had access to education and training with an area of improvement identified. Health care staff involved in aspects of food preparation had not been provided with food hygiene training. This was brought to the attention of the person in charge who assured inspectors action would be taken.

Since the previous inspection all nursing staff had completed training in diabetes management. The new nursing staff would be a facilitated to complete this training. There was evidence that staff had up-to-date training for in mandatory areas such as fire safety training and safeguarding vulnerable adults.

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:

Deirdre Byrne
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: | Lucan Lodge Nursing Home |
| Centre ID: | OSV-0000061 |
| Date of inspection: | 17/08/2016 |
| Date of response: | 29/08/2016 |

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 02: Governance and Management

Theme:
Governance, Leadership and Management

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

There was no annual review of the quality and safety of care in the centre provided to residents.

1. Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

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

At the time of inspection there was no formal annual review available but an analysis of some parts of our service had taken place which included review of Audits, Policies, and both Family and Resident surveys. However since inspection a more comprehensive review is taking place to include all aspects of our service and will include information on Admissions, Deaths /Discharges, staffing , staff training changes to premises etc These are the formal ways of reviewing the Quality and Safety of Care in the Centre, however there is a day to day review as Staff, Residents and Families are constantly reporting any noticed issues to the Management.

The above information will be correlated into an annual review and submitted to HIQA no later than 28th October or sooner if ready.

Proposed Timescale: 28/10/2016

Theme:

Governance, Leadership and Management

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

The auditing process had not picked up on issues identified by inspectors.

2. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The Nutrition Audit has been reviewed and a question regarding supervision of residents who require modified diets has been added and an existing question has been modified to include choice at meal times to all residents irrespective of their diet.

Proposed Timescale: 29/08/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

A certificate confirming that their had been quarterly servicing of emergency lighting had not been provided.

3. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

Currently, Lucan Lodge's electrician generates his own records of quarterly services which are kept in Lucan Lodge and are acknowledged by Management. From now on, the electrician will provide us with a signed certificate as well.

Proposed Timescale: 29/08/2016

Outcome 09: Medication Management

Theme:

Safe care and support

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

Temperature controlled medicines were not securely stored on one floor.

4. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Staff Nurses were informed about HIQA's findings. All Staff Nurses were reminded that under no circumstances were the fridges to be left unlock at any time. Medication management training is provided to all the Staff Nurses regularly. Fridge has been replaced.

Proposed Timescale: 18/08/2016

Theme:

Safe care and support

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

Some administration sheets did not include the times for documenting when medicines were administered.

5. 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:

The mentioned sheets are no longer used by Lucan Lodge, however ONE of these old sheets was found and incorrectly used by one of the Staff Nurses. All Staff Nurses have been reminded that if they find a MAR Sheet with no specified medication time, these

must be shredded, and breakfast, lunch, dinner and bedtime is not acceptable.

Proposed Timescale: 18/08/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The natural light to the lower ground floor bedrooms and dining rooms is blocked by an external wall.

6. 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:

As explained in previous correspondence this work will have to be done from cash flow. To date expenditure has been focused on redecoration ,recruitment, IT software and equipment. We hope to have work outside completed by Dec 2017.The outside wall will be stepped back and in front of windows will be landscaped to allow more natural light into rooms.

Proposed Timescale: 31/12/2017

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

Some residents on modified diets were not being offered choice at mealtimes.

7. 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:

Residents on minced and moist diet are now offered different choices at meal times. Our Menu has been expanded to provide 2 choices of soft diet. Menus have been changed to reflect this. We have designed a menu for people on modified diets and a care staff asks each person what they wish to have for dinner the next day and this is marked on diet sheet .These sheets are send to kitchen for the chef who prepares food

according to choices.

Proposed Timescale: 28/09/2016

Theme:

Person-centred care and support

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

The instructions from in residents' care plans regarding fortification of diets and modified texture of meals were not being consistently followed by staff.

8. Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

The changes of Residents' diet are discussed with the Care Staff on the daily basis as they occur. A folder has been prepared for each floor detailed any special diet that is required by any resident. These folders are kept in the nurse's station and the CNM1 is responsible for updating them. A Staff Nurse is present in each dining room at mealtimes to ensure staff follow the recommendations.

Proposed Timescale: 29/09/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The staff nurse skill mix for both day and nights shifts requires regular review.

9. 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:

Starting from 30th August 2016 we now have 3 Nurses on night duty at all times

Proposed Timescale: 30/08/2016

