<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Thomond Lodge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000109</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Ballymahon, Longford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>090 643 8350</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@thomondlodge.com">info@thomondlodge.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Thomond Care Services Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Sean Kelly</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Patricia Ennis</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary McCann</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Thelma O'Neill</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on</td>
<td>48</td>
</tr>
<tr>
<td>the date of inspection:</td>
<td></td>
</tr>
<tr>
<td>Number of vacancies on</td>
<td>1</td>
</tr>
<tr>
<td>the date of inspection:</td>
<td></td>
</tr>
</tbody>
</table>
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 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 February 2014 09:30</td>
<td>12 February 2014 19:00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 02: Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 03: Suitable Person in Charge</td>
</tr>
<tr>
<td>Outcome 04: Records and documentation to be kept at a designated centre</td>
</tr>
<tr>
<td>Outcome 05: Absence of the person in charge</td>
</tr>
<tr>
<td>Outcome 06: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Medication Management</td>
</tr>
<tr>
<td>Outcome 09: Notification of Incidents</td>
</tr>
<tr>
<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
</tr>
<tr>
<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
</tr>
<tr>
<td>Outcome 17: Residents clothing and personal property and possessions</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
</tr>
</tbody>
</table>

**Summary of findings from this inspection**

This was an announced inspection in response to an application by the provider to the Health Information and Quality Authority (the Authority) to renew registration of this centre. The current registration of this centre is due to expire in April 2014. This was the eleventh inspection of this centre undertaken by the Authority.

In order to apply for renewal of registration the provider must submit required documentation to the Authority. Prior to the inspection the inspectors reviewed written evidence, from a suitably qualified person confirming the building meets all the statutory requirements of the Fire and Planning Authority, with regard to the use of the building as a residential centre for older people. In addition all other documents submitted by the provider, for the purposes of renewal of registration were reviewed prior to the inspection.
Eleven residents and five relatives completed a pre-inspection questionnaire which was also reviewed. The Inspectors found that residents and relatives were positive in their feedback and expressed satisfaction about the facilities, services and care provided. Many residents mentioned that the provider was in the centre daily and if they had a concern they could talk to him. Residents who spoke with inspectors during the inspection were complimentary about their day to day life experiences, the meals provided and the staff team.

The fitness of the provider representative and the person in charge was determined by interview during the previous registration inspection and ongoing regulatory work, including subsequent inspections of the centre and level of compliance with actions arising from inspections.

As part of the inspection process, inspectors met with residents, relatives and staff members, observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Systems were in place to ensure a safe environment was provided to residents. There were policies, procedures, systems and practices in place to assess, monitor and analyse potential risks with control measures in place to ensure risk minimisation.

The person in charge and her deputy demonstrated their knowledge of the legislation and standards throughout the inspection process. The provider representative attended the feedback meeting and voiced a willingness to continually work with the Authority to ensure compliance with current legislation.

An unannounced monitoring inspection had previously been carried out by the Authority, in May 2013. The two areas which required review from the previous inspection which related to medication management and dementia care had been addressed.

Post this inspection, information was received by the Authority raising a concern with regard to the level of care staff on night duty. Findings on this inspection with regard to staffing are documented under Outcome 18.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.
### Outcome 01: Statement of Purpose

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

**Theme:**
Leadership, Governance and Management

**Judgement:**
Compliant

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
There was a written statement of purpose which consisted of a statement of the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations. A copy of the updated statement of purpose was available for the inspectors during the inspection.

### Outcome 02: Contract for the Provision of Services

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

**Theme:**
Leadership, Governance and Management

**Judgement:**

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
A sample of the contracts of care were reviewed by inspectors. These had been agreed with the resident and or their representative within one month of their admission, however all contracts required review as the fees had recently been reviewed. While an overall fee was documented the fees payable by the resident for the service provided was not detailed. An additional fee for the provision of social care programmes and other services deemed not included in the fair deal scheme was recorded but this was
by way of a blanket fee and was not itemised to ensure transparency.

**Outcome 03: Suitable Person in Charge**  
*The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Leadership, Governance and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Judgement:</strong></td>
<td>Compliant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outstanding requirement(s) from previous inspection:</strong></th>
<th>No actions were required from the previous inspection.</th>
</tr>
</thead>
</table>

**Findings:**  
The designated centre is managed by Patricia Ennis, a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. There is a clearly defined management structure which identified the lines of authority and accountability in the centre.

The person in charge demonstrated sufficient clinical knowledge and a sufficient knowledge of the Regulations and her statutory responsibilities. Inspectors were satisfied that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis and was committed to professional development.

Residents were familiar with and complimentary of the person in charge and staff team. She is supported in her role by the provider who was available in the centre on a daily basis, a clinical nurse manager, nursing, care, administration and ancillary staff. Staff were familiar with the organisational structure and confirmed that good communication existed within the staff team. She and the staff team facilitated the inspection process, she had appropriate documentation prepared and easily accessible on arrival for the inspectors. She had good knowledge of residents’ assessed needs, their planned care and conditions. From the staff roster and speaking with the person in charge she confirmed that she worked three days per week in the delivery of care to residents. She described this as the most enjoyable part of her post and it gave her a good opportunity to keep up to date with the clinical status of the residents and an opportunity to supervise the delivery of care to residents and attend handover. She and her staff team promoted a philosophy of care which was resident focused. Residents spoken to were aware of the person in charge and confirmed they saw her most days.

The person in charge maintained her professional development and had recently completed a course in diabetic care and a care homes early warning signs (CHEWS) course, management of anaphylaxis and a safety workshop. She has in the past completed the special purpose award in gerontology. Her mandatory training in adult protection, manual handling and fire safety and her registration with an Bord Altranais...
Outcome 04: Records and documentation to be kept at a designated centre
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Minor

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

Findings:
At the time of the last inspection inspectors found that the cause of death for residents who died at the centre was not recorded in the directory of residents and the directory did not have the facility to record the sex of each resident. While these issues had both been addressed the directory continued to failed to comply with Regulation 23: Directory of Residents and include all of the information specified in Schedule 3 of the Regulations. The contact details of the next of kin of all residents was not recorded.

All of the written operational policies as required by schedule 5 of the legislation were available.

The inspectors found that records required by current legislation were generally maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

Outcome 05: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.
### Findings:
The provider and person in charge were aware of their responsibility to notify the Chief Inspector of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence. The fitness of the deputising person in charge - Sarah Murphy was determined by interview during this inspection. She was found competent. She had qualified as a registered nurse in 2009 and was appointed to the post of Clinical Nurse Manager 2013. She worked full-time in the centre and had maintained her professional development. She recently completed a course on CHEWS, medication management, foot screening and associated education of patients with diabetes, hip replacement and total knee replacement, dementia care, Alzheimer’s care, special purpose award in care of the older person and had a certificate in respiratory nursing. Her mandatory training in adult protection, manual handling and fire safety and her registration was up-to-date with an An Bord Altranais.

### Outcome 06: 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.*

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Safe Care and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgement:</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The action(s) required from the previous inspection were satisfactorily implemented.</td>
</tr>
</tbody>
</table>

### Findings:
The financial processes in place to ensure the safeguarding of residents’ finances were examined by one of the inspectors. At the time of the last inspection the inspectors noted there were discrepancies between the balances recorded and the amount of money held in safe keeping in the case of two residents’ finances being managed. This had been addressed and money available for residents was cross referenced with accounts available and no discrepancies were found.

There was a policy outlining procedures to guide staff on the management of residents’ personal property and possessions. Transparent records of the handling of residents’ money was maintained for each transaction and a separate account was available for each resident. Two signatures were recorded in all instances.

### Safeguarding and protection:
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to manage incidents of elder abuse. This included information on the various types of abuse, assessment, reporting and investigation of incidences.
The training records identified that staff had opportunities to participate in training in the protection of residents from abuse. During discussions with the inspectors some staff members demonstrated their knowledge regarding reporting mechanisms within the centre and what to do in the event of a disclosure about actual, alleged, or suspected abuse. Staff were clear that the welfare of the resident was their paramount concern. Staff were aware of the contact details of the local HSE Senior Case Worker.

There was a visitors’ record located by the reception area to monitor the movement of persons in and out of the building to ensure the safety and security of residents. The inspectors saw that this was signed by visitors entering and leaving the building. The centre was further monitored by closed circuit television cameras at entrance and exit points. Residents confirmed that they felt safe in the centre and contributed this to the presence of staff and the doors being secure.

### Outcome 07: Health and Safety and Risk Management

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

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Safe Care and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Judgement:</strong></td>
<td>Non Compliant - Minor</td>
</tr>
</tbody>
</table>

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

**Findings:**
At the time of the last inspection there was no system of checks on work practices and the premises through regular audits to ensure a pro active response to minimise potential hazards. This had been addressed. A monitoring audit programme had been developed to anticipate any potential hazards which may occur in the centre. Sections of the centre were audited on a monthly basis. Where hazards were identified these were acted upon, for example, identified maintenance issues.

**Risk management:**
A risk management policy was in place but this failed to comply with current legislation. The policy covered the identification, management and control of risks. Policies were available on assault, aggression and violence and self-harm but no policy was available with regard to arrangements for the learning from serious untoward incidents or adverse events involving residents. Incidents and accidents were recorded and procedures were put in place to minimise the risk of reoccurrence. For example provision of low-low beds and tactile mats were in use. Additionally, the person in charge informed inspectors that she was in the process of reviewing morning staffing levels as she had found that there was a higher incidence of accidents in the early morning and she was planning on increasing staff levels to ensure a higher level of supervision for residents in the early morning.
Health and Safety:
The health and safety of residents, visitors and staff are promoted and protected. A safety statement was in place. There were a number of prominently displayed procedures at the exits for the safe evacuation of residents and staff in the event of fire. On walking around the premises inspectors noted that there were systems in place to assist in controlling/minimising the risks associated with the environment. For example, the premises were well maintained with safe floor covering and clutter free, equipment was stored appropriately, an emergency call-bell system was available in all bedrooms and toilets, handrails were provided in circulating areas. There was a designated smoking room and a protective smoking apron was available for residents who smoked.

Contracts were in place for the disposal of waste, as well as measures to control and prevent infection. There are arrangements in place for the segregation and disposal of waste, including clinical waste. Hand washing/sanitising facilities are readily accessible to staff. There was a safety statement in place but it was not signed or dated.

Moving and Handling:
All staff had up-to-date training in manual handling. A moving and handling assessment was available for each resident in the case files reviewed. The inspectors observed safe moving and handling practices during the course of the inspection. There were two hoists available to assist staff in safe moving and handling of residents.

Fire Safety:
There are adequate precautions against the risk of fire in place. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of a fire. Fire training was attended by all staff in the past 6 months and there were five fire drills completed in that time. Suitable emergency equipment was provided in the designated centre and the person in charge showed the inspector records which confirmed that contracts were in place to provide quarterly testing. A record of all fire alarm tests carried out at the designated centre was available in a fire safety folder. Fire exits were checked daily by staff to ensure exits were unobstructed and a record was kept of this. In the event of a power outage a generator was in place, with automatic activation within 20 seconds.

Emergency plan:
An emergency plan had been developed which contained procedures to take in the event of loss of heat, water or light, fire or flood. Contingency arrangements were in place should the need for evacuation of residents arise.

Missing person’s policy:
A missing person policy was in place to guide and inform staff should a resident be reported as missing. Recent photographic identification was available for each resident.

Restraint:
Staff informed the inspectors that some residents were using bedrails as enablers in most cases and on occasions as a restraint. There was regular monitoring of the use of these measures. Care plans were in place with regard to the restraint measures however there were no care plans in place with regard to the enabling measures and the rationale of their enablement function. Risk assessments had been completed prior to
the use of all restraint measures and enabling measures to ensure the safety of the residents.

Falls management:
All residents who sustained a fall were subject to neurological observation to ensure they did not sustain a head injury. There were low-low beds, crash mats and sensor mats available to assist with risk reduction to try and prevent re-occurrence of falls. A physiotherapy service was available in the centre for assessments.

**Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Safe Care and Support

**Judgement:**
Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
Inspectors reviewed the medication management policy and found that policies were in place, to ensure guidance to staff from ordering, prescribing, storing and administration of medicines to residents. An inspector accompanied a nurse on the medication round. Photographic identification was available for each resident to ensure the correct identity of the resident receiving the medication, and to reduce the risk of medication error. The inspector found that, the nurses were knowledgeable regarding medication in use. Nursing staff transcribed medication onto prescription charts, however, the procedure was not in keeping with An Bord Altranais Guidelines on medication management which states that “Transcribed orders should be signed and dated by the transcribing nurse and co-signed by the prescribing doctor or registered nurse prescriber within a designated timeframe”. This was not occurring in relation to transcribed medication.

There are procedures for the handling and disposal of unused and out-of-date medicines, but a more robust auditing of the frequency and reasons for disposal of medication is required.

Medications that require strict control measures were kept in a secure cabinet, nurses kept a record of all controlled drugs, and the inspector checked a selection of MDA drugs and found them to match the record.

Three monthly reviews by the general practitioner of medication were occurring. Where residents were responsible for their own medication, an assessment was completed to ensure competency and guidance was available to staff with regard to this practice. Inspectors were complimentary of this practice as it promoted and maintained residents'
independence and prevented de-skilling respite residents.

Prescription sheets included the appropriate information, such as the resident’s name and address, a photo, of the resident. Separate PRN medication sheets were available.

Medications that require strict control measure were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody Regulations) 1984.

**Outcome 09: 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

**Judgement:**
Compliant

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The person in charge was aware of the legal requirement to notify the Chief Inspector according to the regulations. Quarterly returns were suitably submitted as required. During the inspection process inspectors noted that a person had absconded from the centre and this had not been notified to the Authority. The person in charge stated that this was an oversight on her behalf. Some incidents for example a fire in a bin in the garden and loss of heat were notified but the appropriate forms were not utilised. The person in charge put a system in place at the time of the inspection to reduce the risk of this re-occurring and informed the inspectors of this change.

**Outcome 10: Reviewing and improving the quality and safety of care**

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

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Minor

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.
Findings:
A system for quality assurance and continuous improvement was in place. Audits were undertaken on varied aspects of the service and included falls and medication management. While there were improvements identified and practice in several areas had improved such as a decrease in falls there was no overall report completed on the quality and safety of care and quality of life in accordance with Regulation 35.

A summary of the audit findings was available following a review of each audit, for example, the number of falls that occurred each month and the time the falls took place. There was a lack of clinical audits with regard to for example weight management, pressure area care or pain management. A report in respect of audits completed had not been devised and made available to residents and for inspection. Regulation 35 (2).

Outcome 11: Health and Social Care Needs
Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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

Judgement:
Non Compliant - Minor

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspector found that a good standard of nursing care was provided to residents. Residents reported that they were very well cared for and residents looked well cared for. There were no residents with pressure ulcers on the day of inspection. The inspector observed the delivery of appropriate care to residents and observed that nurses spoken with described the delivery of good care to residents which met their needs (with the exception of one breach of privacy as described under Outcome 16). Staff were observed to be caring and kind in their approach to residents and residents told the inspectors “staff were caring and kind and look after us well”.

From an examination of a sample of residents' care plans, discussions with residents, relatives and staff the inspectors were satisfied that the nursing and medical care needs of residents were assessed and appropriate interventions/treatment plans implemented. For example, there was information which detailed residents' choices with regard to daily routines, risk assessments such as dependency, moving and handling, falls, use of bedrails, nutrition, continence and the risk of pressure sores.
However, the care plans required further work to ensure they provided guidance to staff in the delivery of person-centred care to residents and reflected the advice of allied health professions input. While there were care plans in place for emergency medical situations for example hypoglycaemia, hyperglycaemia and status epilepticus, these care plans required review to ensure they detailed a high standard of evidence-based nursing practice.

There was evidence available of involvement of the resident or their significant in the development and review of their care plan. However, this was only by way of a signature. There was no narrative note that a discussion had taken place with the resident particularly where a resident is cognitively impaired to try and ensure that the resident understands in broad terms the nature of the care to be provided. A record of the residents’ health condition and treatment given which was linked to the care plan was completed twice daily. The person in charge described good access to general practitioner (GP) services. There was good access to allied health professional services including physiotherapy, occupational therapy, dietician and speech and language therapy services. A chiropodist attended the service regularly. Audiology services were arranged as required via GP referral. Eye checks were also arranged as required. There was access to the local palliative care team.

The person in charge informed the inspectors that there was one resident who could potentially display behaviour that challenges. Inspectors reviewed the care plans with regard to challenging behaviour and found that behaviour monitoring logs were in place. However the care plan required review to ensure a reactive strategy was documented to ensure consistency in dealing with the behaviour if presented. The person in charge informed the inspectors that there was good access to mental health services and the community mental health nurse visited the centre as requested.

From the pre inspection questionnaires and from talking with residents the inspectors saw that there were opportunities for residents to participate in meaningful activities, appropriate to their interests and preferences. These included bingo, exercises, crafts and festive themed events. Mass was available weekly. Inspectors noted that staff took time to sit and chat with residents.

**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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

**Theme:**

Effective Care and Support

**Judgement:**

Non Compliant - Minor
Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The centre is a purpose built building, which has been designed taking into consideration the needs of dependent persons. Overall, inspectors were satisfied that the location, design and layout of the centre was suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. There was appropriate equipment for use by residents or staff which was maintained in good working order.

There were maintenance issues with regards to the environment that required review. These included ensuring there was a lock on each toilet to protect the privacy and dignity of residents, a toilet was noted to be leaking and tiling in one toilet required renewing. The provider representative informed the inspectors at the feedback meeting that he had arranged for these maintenance issues to be addressed. There was also evidence from minutes of management meetings that the toilet issues had been discussed and a plan was documented to rectify.

There are a variety of communal areas such as sitting, visitors, library, oratory and dining room. Additional rooms include treatment/clinical care, storage, administrative area, cleaners’ room and a sluice room. Adequate car parking is available to the front and side of the centre.

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

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
There was a written operational policy and procedure relating to the making, handling and investigation of complaints. The procedure identified the nominated person to investigate a complainant and the appeals process. This was displayed in a prominent position and residents and relatives who submitted pre inspection questionnaires were aware of the process and identified mainly the person in charge as the person whom they would communicate with if they had any issue of dissatisfaction. The inspector examined the complaints record. Four complaints had been documented in the previous six months. All had been resolved. Records showed that complaints were promptly investigated and detailed the outcome for the complainant and whether the complainant
was happy with the outcome. One resident said if she had a complaint she “would bring it to the manager and she would deal with it very well”.

### Outcome 14: End of Life Care

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

#### Theme:

Person-centred care and support

#### Judgement:

Non Compliant - Minor

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

No actions were required from the previous inspection.

#### Findings:

At the time the inspection there were no residents receiving end-of-life care. There was an end-of-life policy in place which appropriately addressed the care practices which should be implemented for an individual at the end of their life. All residents had single rooms and the person in charge informed the inspectors that family members usually stayed with their loved one in the single room, the visitors room which had tea and coffee making facilities was also available for families. While the spiritual designation of resident was recorded in the care files, no end-of-life care plans had been developed. The person in charge and her deputy stated that they were aware this was an area that required input and it was their intention to address it as soon as the registration renewal inspection was completed. The person in charge confirmed that there was good access to palliative care services.

### 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

#### Judgement:

Compliant

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

No actions were required from the previous inspection.
**Findings:**
Residents were provided with food and drink in quantities adequate for their needs. Residents' weights were recorded according to their clinical status. There was good monitoring of nutritional intake of residents at risk nutritionally. An inspector observed the lunchtime meal and saw that the food was served in an appropriate manner and residents spoken with were complimentary of the food. Comments such as "the food is great, we get as much as you want" "it’s always good" were made by residents. Most residents could eat their lunch with minimal assistance and those who required assistance from staff were assisted in a discreet and sensitive manner.

---

**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.*

**Theme:**
Person-centred care and support

**Judgement:**
Non Compliant - Minor

---

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

---

**Findings:**
An inspector observed a practice that was not sensitive to residents’ needs and did not promote privacy and dignity, for example administering an insulin injection in a communal area.

There was evidence of a good communication amongst residents and the staff team. Residents were dressed appropriately and told the inspectors that they could choose what to wear. A residents’ committee was in place and meetings were held every two months. There was a good attendance at these. Minutes were available for residents who did not attend. Copies of the residents’ guide and statement of purpose were available in the reception area. Residents’ religious, political and religious rights were respected. The provider confirmed that residents would be able to vote in the upcoming election if they so wished.

Residents had access to a variety of national and local newspapers. The person in charge told the inspectors that there was access to an advocate who regularly attended the centre.
**Outcome 17: Residents clothing and personal property and possessions**

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

**Theme:**
Person-centred care and support

**Judgement:**
Compliant

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
Inspectors saw that there was adequate space provided for residents’ personal possessions. Residents had a locked facility in their bedrooms. There were arrangements in place for regular laundering of linen and clothing. No resident or relative raised any issue with inspectors with regard to the safe return of clothes to residents.

**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.

**Theme:**
Workforce

**Judgement:**
Compliant

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

**Findings:**
At the time of the last inspection inspectors found that the provider had not ensured that all staff had been Garda Síochána vetted prior to employment. The inspectors examined the documents to be held in respect of four persons working at the centre and found that the provider had put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 (this includes verified Garda Síochána vetting) of the Regulations have been obtained in respect of each person.
On the day of inspection the person in charge was on duty supported by two nurses and six care assistants to deliver care to residents up to 2:00 pm. This decreased by one carer post 2:00 pm. Catering and household staff were also rostered. One nurse and three carers were rostered from 8:00 pm until 10:00 pm with one nurse and two carers available from 10:00 pm until 8:00 am. From review of additional rosters past and planned for the following week the inspectors noted that these were the standard staffing levels. The person in charge informed the inspectors that when staff were off sick or on leave that they were usually replaced by staff who worked part-time.

At the time of this inspection there were 47 residents living in the centre, nine of whom were maximum dependency, eight were high dependency, 20 were medium dependency and 10 were low dependency. Residents had a mixture of age related medical conditions and cognitive impairment. Inspectors were satisfied that the numbers and skill mix of staff was appropriate to the assessed needs of residents and the size and layout of the centre on the day of inspection. Inspectors formed this opinion as residents were satisfied that members of staff were available to them as required, staff and relatives spoken with expressed no concern with regard to staffing levels, call-bells were answered in a timely fashion there was adequate staff to assist residents with nutritional intake, staff were seen to have time to spend with residents and staff told inspectors that they were happy with the level of staffing on days and nights at the centre.

As discussed under Outcome 7 the person in charge stated that she was reviewing care staff levels in the early morning due to the findings of a recent falls audit. From analysis of the pre inspection questionnaires there was one questionnaire which stated that there was a requirement for extra care staff on nights. As stated in the summary of findings post this inspection, the Authority received unsolicited information with regard to the level of care staff on night duty. Inspectors spoke with the person in charge with regard to night staffing levels and they were 1 nurse and three carers up to 10:00 pm and one nurse and two carers from 10:00 pm to 8:00 am. From review of the accident and incident record discussion with staff and residents coupled with analysis of the questionnaires the inspectors felt the current staff levels met the assessed needs of residents. This staffing level needs to be kept continually under review depending on the assessed needs of the residents. The person in charge confirmed that she would continue to review the staffing levels and if there was a need identified for further staff or a change in shift patterns then she would put it in place.

Staff had received mandatory training and an ongoing plan aimed at providing support for staff to undertake education and training to meet the needs of residents was described. Inspectors found that the personal identification number (PIN) to confirm registration with An Bord Altranais was available for all staff nurses rostered.

The person in charge informed the inspectors that she had time to complete her management duties and responsibilities of her role. Systems of communication were in place to support staff to provide safe and ensure appropriate care. There were two handovers each day to ensure good communication and continuity of care throughout a 24 hour period.
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Mary McCann
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider's response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Thomond Lodge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000109</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>12/02/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19/03/2014</td>
</tr>
</tbody>
</table>

**Requirements**

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 04: Records and documentation to be kept at a designated centre**

**Theme:** Leadership, Governance and Management

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

The Directory of Residents did not include all of the information specified in Schedule 3 of the Regulations. The contact details of the next of kin of all residents was not recorded.

**Action Required:**

Under Regulation 23 (2) you are required to: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

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

The directory of residents has been updated to include contact details of all next of kin.

**Proposed Timescale:** 10/03/2014
**Outcome 07: 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:**

The risk management policy was silent with regard to arrangements for the identification, recording, investigation and learning from serious untoward incidents or adverse events involving residents.

**Action Required:**
Under Regulation 31 (2) (d) you are required to: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
A policy on the identification, recording and investigation of untoward incidents has now been put on place and same included.

**Proposed Timescale:** 10/03/2014

---

**Outcome 08: Medication Management**

**Theme:** Safe Care and Support

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

Nursing staff transcribed medication onto prescription charts but the procedure was not in keeping with An Bord Altranais Guidelines on medication management which states that “Transcribed orders should be signed and dated by the transcribing nurse and co-signed by the prescribing doctor or registered nurse prescriber within a designated timeframe”.

**Action Required:**
Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

**Please state the actions you have taken or are planning to take:**
The nurse transcribing now signs the order and same co-signed by the GP. Policy has been amended to include same.

**Proposed Timescale:** 10/03/2014
**Theme: Safe Care and Support**

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A robust auditing of the frequency and reasons for disposal of medication was required.

**Action Required:**
Under Regulation 33 (2) you are required to: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

**Please state the actions you have taken or are planning to take:**
The reason for disposal of medications will now be recorded and shall be audited in line with our medication audits. Our policy on disposal of medication has been amended to ensure that all staff are aware of the importance of recording reason for disposal of medication. Audit of same will be done with next medication audit due in May.

**Proposed Timescale:** 10/03/2014

---

**Outcome 10: Reviewing and improving the quality and safety of care**

**Theme: Effective Care and Support**

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of clinical audits with regard to for example weight management, pressure area care or pain management. A report in respect of audits completed had not been devised and made available to residents and for inspection. Regulation 35 (2).

**Action Required:**
Under Regulation 35 (2) you are required to: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
Whilst audits and reports were being carried out in the above areas, an over all report to reflect all audits was not carried out and all of this information was not being passed on to the residents. This will commence and a report will be relayed to all residents twice yearly at our residents meetings.

**Proposed Timescale:** 01/05/2014
## Outcome 11: Health and Social Care Needs

### Theme: Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The there was evidence available of involvement of the resident or their significant in the development and review of their care plan. However, this was only by way of a signature. There was no narrative note that a discussion had taken place with the resident particularly where a resident is cognitively impaired to try and ensure that the resident understands in broad terms the nature of the care to be provided.

**Action Required:**
Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

**Please state the actions you have taken or are planning to take:**
Evidence that a discussion has taken place shall be documented following review of care plans and in particular where a resident is cognitively impaired.

**Proposed Timescale:** 10/03/2014

### Theme: Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors reviewed the care plans with regard to challenging behaviour and found that behaviour monitoring logs were in place. However, the care plan required review to ensure a reactive strategy was documented to ensure consistency in dealing with the behaviour if presented.

**Action Required:**
Under Regulation 8 (1) you are required to: Set out each resident’s needs in an individual care plan developed and agreed with the resident.

**Please state the actions you have taken or are planning to take:**
Care plan for the above has been reviewed and reactive strategy has been included to existing care plan.

**Proposed Timescale:** 10/03/2014

### Theme: Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The care plans required further work to ensure they provided guidance to staff in the delivery of person-centred care to residents and reflected the advice of allied health professions input.
While there were care plans in place for emergency medical situations for example hypoglycaemia, hyperglycaemia and status epilepticus, these care plans required review to ensure they detailed a high standard of evidence-based nursing practice.

**Action Required:**
Under Regulation 8 (1) you are required to: Set out each resident’s needs in an individual care plan developed and agreed with the resident.

**Please state the actions you have taken or are planning to take:**
We are in the process of developing a new policy on epilepsy. These will be developed to meet the specific needs of the resident with epilepsy.

**Proposed Timescale:** 30/04/2014

**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 there were maintenance issues with regards to the environment that required review. These included ensuring there was a lockable lock on each toilet to protect the privacy and dignity of residents, a toilet was noted to be leaking and tiling in one toilet required renewing.

**Action Required:**
Under Regulation 19 (3) (b) you are required to: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
Tiling of toilets was completed on 13th February and a new lock was fitted to the toilet.

**Proposed Timescale:** 13/02/2014

**Outcome 14: End of Life Care**

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While the spiritual designation of resident was recorded in the care files, no end-of-life care plans had been developed.

**Action Required:**
Under Regulation 14 (1) you are required to: Put in place written operational policies and protocols for end of life care.
Please state the actions you have taken or are planning to take:
We are in the process of developing a more appropriate resident centred end of life care plan.

Proposed Timescale: 30/06/2014

Outcome 16: Residents Rights, Dignity and Consultation

Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An inspector observed a practice that was not sensitive to residents’ needs and did not promote the privacy and dignity of a resident for example administrating an insulin injection in a communal area.

Action Required:
Under Regulation 10 (c) you are required to: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

Please state the actions you have taken or are planning to take:
Staff have been made aware to be more vigilant when carrying out any nursing duties and the importance of providing privacy and dignity. Insulin administration shall now be carried out in a more private manner.

Proposed Timescale: 10/03/2014