<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Lawson House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000244</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Knockrathkyle, Glenbrien, Enniscorthy, Wexford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>053 923 3945</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@lawsonhouse.ie">info@lawsonhouse.ie</a></td>
</tr>
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<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Lawson House Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Christine Brett Moroz</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ide Cronin</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

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

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.
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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 04 February 2016 09:30
To: 04 February 2016 19:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
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<td>Outcome 05: Suitable Staffing</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 08: Governance and Management</td>
<td>Not applicable</td>
<td>Non Compliant - Major</td>
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Summary of findings from this inspection
This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also considered progress on some findings following the last inspection carried out on 16 April 2014 and to monitor progress on the actions required arising from that inspection.

The centre did not have a dementia specific unit and at the time of inspection there were 30 residents of the 57 that had a formal diagnosis of dementia. Inspectors observed that many of the residents required a high level of support and monitoring due to the complexity of their individual needs.
The provider had submitted a completed self assessment tool on dementia care to the Authority with relevant policies and procedures prior to the inspection. The provider had assessed the compliance level of the centre through the self assessment tool but the findings of inspectors did not accord with the provider's judgements. Although some progress was made by the provider in implementing the required improvements identified on the registration inspection in April 2014, some of the findings at that time were again evident on this inspection. There was a high turnover of nursing staff and a significant number of nursing posts remained vacant despite an ongoing recruitment campaign. This resulted in the person in charge and nurses working many additional hours which was unsustainable. In addition the person in charge was unable to devote the required time to her role as provider and person in charge. The governance and management outcome was monitored and judged to have a major non-compliance.

The inspectors found that the person in charge who was also the provider nominee did not have the capacity to have robust oversight of the centre to ensure that safe effective care was provided to residents. This was due to her spending considerable time delivering nursing care and this impacted on her ability to effectively fulfil her managerial role. Staff rosters were reviewed and inspectors found that there were some weeks that the person in charge worked in excess of 72 hours, which is in excess of the working time act. There was no definitive deputy person in charge identified.

On the day of inspection the person in charge was working within the staff compliment that day. Inspectors observed that she was also supervising two recently recruited nurses. One of whom was a qualified nurse from another country awaiting their nursing registration number with the Irish nursing board.

Outcome 4 was found to be compliant and moderate non compliances were found under Outcomes 1, 2, 3, 5 and 6. Risks associated with standards of clinical care which included assessments and care plans, the management of behaviour that challenge, supervision of practice, nursing staffing levels, medication management. Residents did not have free access to an outdoor space and aspects of the physical environment required improvement in order to support people with dementia.

At the feedback meeting at the end of the inspection, the findings were discussed with the provider nominee/person in charge and the services manager. Due to the number and nature of the findings and the number of non compliances found, the provider was advised that no new residents should be admitted to the centre until the staffing levels and skill mix were sufficient to meet the needs of residents.

Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed 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.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
The well-being and welfare of residents with dementia were generally maintained. However, the standard of some aspects of care was found to be inadequate. Mental health assessment procedures, management of behaviours that challenge and medication management required significant improvement to ensure residents’ needs were met to a satisfactory standard.

Inspectors reviewed a sample of residents’ nursing and medical records. These records confirmed that residents were assessed prior to admission to the centre by the acute or primary nursing and medical team. Although the person in charge did not consistently visit all residents prior to admission to the centre in hospital or in their home, she completed an assessment by telephone.

Pre-admission telephone assessment information was obtained from residents’ families or hospital staff. However, the inspectors found that pre-admission documentation was scant in some case records and not recorded in others. This finding supported a requirement for improvement in pre admission assessment procedures to ensure the service could meet the needs of residents including those with dementia. On admission to the centre, all residents were assessed. However, this documentation did not support adequate assessment of mental well-being and cognitive function of residents with a diagnosis of dementia. A variety of risk assessment tools were used to assess the level of support residents required and findings were set out in an individual care plan. Each residents’ risk of falling was assessed and appropriate measures were identified to address the care needs of residents who fell in the centre. However, staffing levels in the centre did not consistently support the supervision of residents at risk of falling. This finding is discussed further and actioned in outcome 5: Staffing.

A computerised resident information management system was in place. Staff had completed training on its use. Nursing staff completed daily progress entries. Care staff populated residents’ documentation records with care activities completed by them by means of wall-mounted electronic data pad units located throughout the centre. All residents’ electronic records were password protected.
Each resident with dementia had a care plan completed that identified their needs and the care and support interventions that would be implemented by staff to meet their assessed needs. Inspectors observed some areas where improvements were required in the care planning process to ensure residents’ needs were met in all respects. As previously stated, there was an absence of assessment of mental well-being and management plans for residents with behaviours that challenged.

The inspectors observed a small number of incidents of behaviour that challenged, including a peer to peer incident. Staff were observed to satisfactorily intervene and de-escalate these behaviours. The inspectors noted that antecedents were known to staff but a proactive approach was not evident to mitigate incidents occurring. Behavioural intervention care plans did not describe effective positive behavioural strategies to advise management of behaviours. This is outlined in detail and actioned under Outcome 2.

Arrangements were in place where care plans were reviewed and updated on a regular basis by staff. The inspectors were told that residents or their next of kin were involved in the care planning review process. However, this was not consistently documented in residents’ care plans.

Systems were in place for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting. Discharge letters for residents who spent time in acute hospital care were available. While, there was evidence that staff made every effort to ensure that relatives accompanied residents with dementia to hospital and out-patient clinic appointments, there was opportunity for improvement in this area. A summary letter was completed by staff for residents requiring in-patient care in the acute hospital which addressed physical care needs but lacked detail about residents’ communication or psychosocial needs.

There were assessment and care procedures in place to ensure residents' dietary and hydration needs were met. Residents’ weights were checked on a monthly basis and weekly if evidence of unintentional weight loss was found. There was one resident observed to have lost weight. The inspectors observed that interventions were implemented immediately in the form of food supplements, prescribed by the resident’s GP. Referral for review by a dietician was not evident in the care documentation reviewed. The inspectors were told that a community dietician attends the centre on a twice annual basis. Residents’ documentation evidenced referral and review by speech and language therapy services. Recommendations made on consultation were transferred into residents’ care plan interventions as appropriate. Reference sheets were available to all staff including catering staff outlining residents’ special diets including diabetic, modified consistency diets and thickened fluids. Diet and fluid intake records were used as appropriate.

The inspectors observed residents having their lunch in the dining room. A choice of meal was offered to residents on the previous afternoon and again on the day of inspection. Snacks and refreshments were provided between mealtimes. There was adequate staff available to assist residents with eating where required. Mealtime was
observed to be a relaxed occasion. An arrangement was in place where residents who needed assistance with eating, received their meal first, while the other residents enjoyed recreational activities in the sitting room. During mealtime, staff sat beside residents on a one to one basis giving assistance discreetly. Staff were observed to maximise all opportunities to promote each resident’s independence with eating their meal at their own pace, to improve and maintain their functional capacity. Residents were observed to be patiently and gently encouraged throughout their meal. Staff were also observed to use this time as an opportunity to chat to residents about their day and reminisce about their lives, achievements, experiences and families.

There was a recently updated written operational policy available to advise staff on ordering, prescribing, storing and administration of medicines to residents. An inspector observed medication administration at lunchtime on the day of inspection and noted that details of all medicines administered were recorded. The inspector found that medication administration did not meet professional standards and prescribing requirements in some areas. There was evidence that an unregistered nurse was administering medication. The provider/person in charge was advised of these findings on the day of inspection as follows:

- some medications for PRN (as required) administration were not prescribed for PRN use and maximum dosage over a 24hr period was not stated.
- medications administered in crushed format were not individually prescribed
- medication administration documentation templates required review.

There was evidence that the pharmacist was facilitated to meet their obligations to residents. Residents had access to primary care and specialist medical services. Residents admitted to the centre were facilitated a choice of medical practitioner.

There was an end-of-life care policy detailing procedures to guide staff. The policy in the centre is that all residents are for resuscitation unless documented otherwise. Care plans were found to reference the religious needs, social and spiritual needs of each resident. Individual religious and cultural practices were facilitated. There was a small oratory available for prayer and quiet reflection accessible to residents. While end of life care needs were identified on admission and updated accordingly there was limited evidence of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell. Decisions concerning future healthcare interventions required review. Resident’s preferences with regard to transfer to hospital if of a therapeutic benefit were not documented in all of the end-of-life care plans reviewed.

There were issues of capacity to make decisions that staff had to consider as some residents were highly dependent or had dementia or a combination of complex conditions. There was a policy on consent however; inspectors were unclear of the process used to obtain a valid consent in accordance with legislation and current best practice guidelines. There was evidence in medical records that end-of life care decisions regarding resuscitation were documented by the GP. However, there was inconsistent evidence of discussion or input from residents or relatives on the record or on a separate consent form to confirm this decision. Inspectors did not observe that these decisions were reviewed or updated regularly to assess the validity of the clinical
judgement on an on going basis.

**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
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 policy outlined clear guidance for staff as to what their role would be in reporting and managing allegations or suspicions of abuse.

Staff spoken to by the inspectors confirmed that they had received recent training on recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Staff confirmed that there were no barriers to raising issues of concern. Inspectors spoke with some relatives during the inspection who were satisfied with the overall level of care being provided, and stated that any concerns they raised were addressed.

There were policies in place on behaviours that challenged and the use restrictive practices. However supporting assessment tools were not available the policies were not implemented in practice. Inspectors reviewed a selection of care plans to include residents who displayed behaviours that challenged. Staff who spoke with inspectors were knowledgeable regarding residents' behaviours and could identify potential triggers to an onset of behaviours. The policy of the centre in relation to behaviours that challenge outlined that all residents with behaviours that challenge would have a standardised assessment completed. There was no standardised assessment tool to assess behaviours. Clear strategies were not outlined to support a consistent approach to the management of behaviours that challenge or that focussed on a proactive and positive approach.

Strategies were not outlined to support staff in relation to all the behaviours specific to the resident. The care plans did not sufficiently outline the antecedents and communication functions of the behaviours displayed which, when identified promptly, would guide staff to support residents in preventing incidents of behaviour that challenged. Inspectors observed that non-restrictive interventions were not always outlined to guide staff such as redirection, noise reduction, distraction and diversion. A
review of training records indicated that staff were not provided with up-to-date knowledge and skills, appropriate to their role to enable them to manage and respond to behaviour that is challenging.

Residents with whom the inspectors were able to communicate verbally said they felt safe and secure in the centre, and felt the staff were supportive. Inspectors saw that a training day on dementia had been delivered in house to some staff. However, inspectors were not assured of the content or accreditation of this training in relation to providing evidence based care of people with dementia.

Inspectors found that the use of restraint was risk assessed and records were maintained of the type of restraints or enablers in place. On this inspection each resident requiring restraint had a restraint care plan and a restraint assessment form had also been completed. On each assessment seen, the least restrictive alternative to the use of restraint had been considered and the reason for the restraint was discussed with the resident, family and GP. Checks were in place for the use of restraint and inspectors saw that these were recorded.

Inspectors saw that expert advice from the relevant professionals was sought where necessary before commencing any psychotropic medication or any use of physical restraint. There was no chemical restraint used on a PRN (as required basis. Some residents had seating assessments and were provided with specialist wheelchairs.

The centre maintained day to day expenses for some residents and there was an up to date policy on the security of residents’ accounts and personal property. All transactions were appropriately documented with lodgements and withdrawals co-signed by two staff members as observed by an inspector.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

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:
Some evidence that residents with dementia were consulted with and actively participated in the organisation of the centre was found. Privacy and dignity was respected with personal care delivered in residents’ own bedrooms or in bathrooms. Residents were provided with privacy locks and the right to receive visitors in private. There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends in the large open plan areas which was bright and
spacious. There was limited signage to direct and enable residents with dementia to independently access bathrooms and communal areas.

There was a residents’ committee in operation. An inspector viewed the minutes of the last meeting. There was no evidence that there was a nominated person to act as an advocate for residents with dementia on this committee. This would ensure that any issues raised for residents with dementia are acknowledged, responded too and recorded, including the actions taken in response to issues raised. There was no evidence that feedback was sought from residents with dementia on an on going basis on the services provided to them.

There were two activities coordinators and an activity assistant employed over a seven day period. Inspectors found there was a varied activities programme with arts and crafts, exercise and bingo included. The activity co-ordinator spoke with inspectors and was well informed. She understood the needs of residents with dementia and was creative to ensure residents were provided with activities that met their interests and capabilities.

Residents were facilitated to exercise their civil, political and religious rights. Inspectors were told that residents were enabled to vote in national referenda and elections with the centre registered to enable polling. Inspectors observed that residents’ choice was respected and control over their daily life was facilitated in terms of times of rising/returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Inspectors observed that some residents were spending time in their own rooms, watching TV, or taking a nap. Other residents were seen to be spending time in the various communal areas of the centre. Newspapers and magazines were available as observed by inspectors. However as discussed in outcome 6, access to the garden was restricted by locked doors. This had not been reviewed to ensure it did not negatively impact on residents’ freedom and wishes.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. The observations took place in the activity room and dining area at lunch time. Observations of the quality of interactions between residents and staff in for selected periods of time indicated that the majority of interactions demonstrated positive connective care. Overall, staff were observed to make eye contact use touch and gentle encouragement in low key moderate and supportive tones of voice. Residents had a section in their care plan that their covered communication needs. However, the communication plans were not comprehensive as outlined under Outcome 1. There was a communication policy in place. However, it did not include strategies to effectively communicate with residents who have dementia.

There were notice boards available throughout the centre providing information to residents and visitors. Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities of living. There was an oratory with religious services held regularly. External advocacy services were available to residents. Inspectors did not see any evidence of advocacy services being utilised for any resident.

Judgment:
Outcome 04: Complaints procedures

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:
A complaints process was in place to ensure the complaints of residents, their families or next of kin including those with dementia, were listened to and acted upon. The process included an appeals procedure. The complaints policy which was displayed met the regulatory requirements. Some residents and those relatives spoken to could tell inspectors who they would bring a complaint too. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The inspectors reviewed the roster, improvements were required to ensure the roster was reflective of the shifts and type of shifts worked by employees to meet the needs of residents with dementia. It was unclear from the roster if the allotted times were morning, evening or night.

Inspectors reviewed staffing levels and discussed with the person in charge how workload and dependency levels determined staffing requirements. Given the complex care needs of the residents in the centre inspectors formed the judgement that the staffing numbers and skill mix were not at all times appropriate to meet the assessed needs of residents. Inspectors were informed that on many occasions due to staff shortages the person in charge replaced nursing staff in direct care provision.
Inspectors noted that all nursing staff were working over and above 40 hours per week. The incidence of resident falls recorded in quarter three of 2015 had substantially increased to the number recorded in quarter one of 2015. The person in charge attributed these findings to staff shortages in the centre. There were an average of two nurses and ten carers on duty during the day until 16.00 hours to provide direct care to 57 residents including 53% (30) residents with a diagnosis of dementia. After 16.00 there was a reduction in care staff on duty. Night time staffing levels included two staff nurses and three carers.

Systems of communication were in place to support staff with providing safe and appropriate care. There were hand-over meetings each day to ensure good communication and continuity of care when shifts changed. Staff told the inspectors that they became familiar with all residents and their care needs by means of the daily handover and talking to colleagues. Inspectors saw evidence of supervision for healthcare staff by a senior healthcare attendant who supervised shifts and arranged for regular staff meetings.

All registered nurses had up-to-date registration and care assistants were appropriately qualified. Inspectors were informed that nine whole time equivalent staff nurse posts were vacant since 2015. This was due to staff nurses going abroad and new employment opportunities in the area. Inspectors were told that a recruitment drive was on going and there was one member of nursing staff awaiting their nursing registration. Posts were difficult to fill and the person in charge had created a position of senior care assistant to lead and support staff in the provision of care to residents.

The inspectors saw records of regular meetings between nursing management at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards. In discussions with staff, they confirmed that they were supported to carry out their work by the provider/ person in charge. The inspectors found them to be confident, well informed and knowledgeable of their roles, responsibilities and the standards regarding residents.

The inspectors reviewed staff files and found that not all staff files contained all of the information required by the Regulations, for example, Garda vetting forms and references from most recent employers were not present in a file reviewed. Since the last inspection a system had been introduced to ensure that all volunteers were vetted appropriate to their role and level of involvement.

Mandatory training was in place and staff had received training in fire safety, moving and handling and safeguarding vulnerable persons.

**Judgment:**
Non Compliant - Moderate

**Outcome 06: Safe and Suitable Premises**
**Theme:**
Effective care and support

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

**Findings:**
The centre did not have a dementia specific unit and residents with dementia integrated with the other residents in the centre. The centre was found to be well maintained, warm, comfortably and visually clean. All walkways were clear and uncluttered to ensure resident safety when mobilising. The centre was bright with large windows that optimised natural lighting and view.

Inspectors found that aspects of the layout and design of the centre required improvement to meet its stated purpose in respect of providing accommodation for residents with dementia. Residents’ accommodation was in 57 single and three twin bedrooms with en-suite facilities and two single bedrooms with a wash basin provided. Bedrooms viewed by inspectors were personalised and had adequate storage and space to meet residents’ needs. Doors and fittings in bedroom areas were in contrasting colours to flooring and walls to promote independent access for residents with dementia.

Communal accommodation consisted of a large spacious dining area that opened out onto a veranda, a main sitting room, an adjoining sitting area between the main sitting room and the main corridor and two other rooms used for activities were available to residents. A smoking room, oratory and hairdressing room were also provided. The inspectors observed that residents congregated in the main sitting room and the adjoining seating area, which was open on one side to the corridor. Inspectors observed that the main sitting room and the adjoining seated area were congested and busy at times during the day and the noise levels were quite high.

The communal sitting accommodation environment required improvement in terms of familiar, domestic furnishing and homely features. There was some use of signage and colour cues to make areas more easily identifiable to residents with dementia. For example, bedroom doors were in a contrasting colour to floors and walls. Some bedroom doors had the residents’ name on them but the majority had a room number displayed and were all a similar colour. The inspectors discussed with the person in charge the option of improving the signage throughout the centre in order to further support residents with dementia.

Residents’ accommodation was arranged into four areas, each named after a local river and identified by a differently coloured border around the entrance door off a very wide corridor. Some seating was provided along this corridor for residents to rest if they wished. The entrance doors to the resident accommodation areas were secured on the day of inspection and access required residents to co-ordinate pressing a release button and manually opening the doors. This negatively impacted on their independent access around the centre.
An external garden area containing clearly defined looped pathways and shrubbery of different maturity, colour and texture was provided. However, the doors were secured to the garden and inspectors were told it was not available to residents during the winter months.

**Judgment:**
Non Compliant - Moderate

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**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspection findings supported a requirement for significant improvement in the governance and management of the centre to ensure the needs of residents were met in line with its stated purpose. The inspectors found that there was an organisational structure in place. However, significant improvements regarding management systems were required to ensure compliance with the Regulations and to provide assurances to the Chief Inspector that the centre was being efficiently governed ensuring residents were being delivered a service that was safe, effective and met their needs.

The provider is also the person in charge of the centre. She is supported in her role by a senior staff nurse, a company director/services manager and an accountant. The clinical management structure was not adequately resourced and was not defined in terms of roles, responsibility and clear lines of authority and accountability. Inspectors confirmed contingency plans to replace nurses who left the service were ineffective and unsustainable. The provider/person in charge was frequently part of the care team and was unable to devote the time required to fulfil her managerial role.

The senior staff nurse was not rostered with protected time to complete aspects of her role and responsibilities as a senior member of staff. The duty roster evidenced that senior clinical staff including the person in charge worked in excess of standard full-time working hours on a consistent basis. This is outlined in detail under Outcome 5. Deputising arrangements for absences of the person in charge were not clear. The roles and responsibilities of one staff member was not in line with professional requirements as set out by An Bord Altranais agus Chnáimhseachais Na hÉireann. This is outlined under Outcome 1.

Inspectors found that the system in place to monitor the quality and safety of care and the quality of life for residents required substantial improvement. The inspectors observed that some aspects of clinical care were reviewed. However, the information available was scant, inconsistent and did not identify deficits in practice or positively
inform improvements in the safety and quality of care or the quality of life of residents with dementia. For example, resident falls were recorded appropriately but trends were not reviewed to ensure the resources provided supported the safety needs of residents at risk of falling. An annual review of the Quality of the Service for 2015 was not available.

**Judgment:**
Non Compliant - Major

**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:**

Ide Cronin
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 report

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<th>Lawson House Nursing Home</th>
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<td>OSV-0000244</td>
</tr>
<tr>
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<td>04/02/2016</td>
</tr>
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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 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors were told that residents or their next of kin were involved in the care planning review process. However, this was not consistently documented in residents’ care plans.

1. Action Required:
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan,

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

Please state the actions you have taken or are planning to take:
An in depth review of care plans will be undertaken to improve content. Input of family members or residents will be uniformly documented in future.

Proposed Timescale: 30/06/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed some areas where improvements were required in the care planning process to ensure residents’ assessed needs were met in all respects. Inspectors observed that there was an absence of assessment of mental wellbeing and management plans for behaviour that challenged.

2. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Assessment of mental well being and behaviours that challenge will be addressed as part of the care planning review.

Proposed Timescale: 30/06/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that the process used to obtain a valid consent is in accordance with legislation and current best practice guidelines. In one instance there was no evidence of the residents’ wishes or choices relating to treatment and care being discussed and documented and as far as possible implemented in order to maximise the principle of autonomy.

3. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Chnáimhseachais.
Please state the actions you have taken or are planning to take:
Documentation around consent will be reviewed in line with the National Consent Policy and review of care plans.

**Proposed Timescale:** 30/06/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inconsistencies in relation to the resident involvement in the decision making process relating to end of life care.

4. **Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Chúigeachtaí.

Please state the actions you have taken or are planning to take:
Inconsistencies in relation to resident involvement in the decision making process relating to end of life care will be addressed as part of the care plan review.

**Proposed Timescale:** 30/06/2016

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Transfer documentation identified areas of physical care needs. However, it lacked detail in communicating their individual psychosocial needs.

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

Please state the actions you have taken or are planning to take:
Transfer documentation will be reviewed to include information on psychosocial needs.

**Proposed Timescale:** 30/06/2016

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents’ medication prescriptions did not meet prescribing documentation requirements in the following areas:

- medications were not administered to some residents by a registered nurse
- some medications for PRN (as required) administration were not prescribed for PRN use and maximum dosage over a 24hr period was not stated.
- medications administered in crushed format were not individually prescribed
- medication administration documentation templates required review.

6. 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 nurse working under supervision has now received N.M.B.I registration. PRN medications, medication administration documentation and crushing guidelines will be reviewed.

Proposed Timescale: 31/05/2016

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A review of training records indicated that not all staff had up-to-date training in challenging behaviour.

7. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
Training in behaviours that challenge will be provided to all care staff as part of our training programme 2016.

Proposed Timescale: 30/07/2016
**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no standardised assessment tool to assess behaviour that is challenging with symptoms objectively documented and qualified. Clear strategies were not outlined to support residents to manage behaviour that challenges or that focussed on a proactive and positive approach.

**8. Action Required:**
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
A standardised assessment tool will be used to assess residents who present with challenging behaviour.

**Proposed Timescale: 30/04/2016**

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**Outcome 03: Residents' Rights, Dignity and Consultation**

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that there was a nominated person to act as an advocate for residents with dementia on this committee. There was no evidence that feedback was sought from residents with dementia on an ongoing basis on the services provided to them.

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

Please state the actions you have taken or are planning to take:
We will attempt to identify and appoint an advocate for residents/ residents with dementia, to sit on the resident’s committee.

**Proposed Timescale: 30/03/2016**
Access to the garden was restricted by locked doors. This had not been reviewed to ensure it did not negatively impact on residents’ freedom and wishes.

10. **Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**
Doors are always kept open to the enclosed garden area in summer time and on warm days. We have now designated exit areas into the garden area which will remain unlocked.

**Proposed Timescale:** 01/03/2016

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The communication plans were not comprehensive. The communication policy did not include strategies to effectively communicate with residents who have dementia.

11. **Action Required:**
Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident’s care plan prepared under Regulation 5.

**Please state the actions you have taken or are planning to take:**
Communication with residents with dementia will be addressed as part of the in depth review of care plans.

**Proposed Timescale:** 30/06/2016

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors formed the judgement that the staffing numbers and skill mix were not at all times appropriate to the assessed needs of residents, the size, layout and purpose of the unit.

12. **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:**
There is a recognised national and international shortage of registered nurses, every effort is being made to restore full staffing levels.

**Proposed Timescale:** 30/06/2016

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
It was difficult to ascertain whether or not some mandatory training was provided by accredited trainers. Therefore inspectors were not assured that the training provided enabled staff to meet the needs of residents in accordance with contemporary evidence based practice.

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

**Please state the actions you have taken or are planning to take:**
A training matrix will be put in place to ensure that all mandatory training is compliant with Regulation 16.

**Proposed Timescale:** 30/03/2016

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that aspects of the layout and design of the centre required improvement to meet its stated purpose in respect of providing accommodation for residents with dementia.

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

**Please state the actions you have taken or are planning to take:**
Two new lounge areas will be created and appropriately decorated for residents
diagnosed with dementia.

**Proposed Timescale:** 30/04/2016

### Outcome 08: Governance and Management

**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors confirmed that the provider/person in charge was frequently part of the care team as a measure to replace unplanned leave/ staff shortage.

15. **Action Required:**
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
Management structures are in place and clearly defined, a national shortage of nurses has made recruitment and retention of nursing staff extremely difficult. We will continue to source nurses through all available channels.

**Proposed Timescale:** 30/06/2016

**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An annual review of the Quality of the Service for 2015 was not available.

16. **Action Required:**
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
Annual review of quality and safety of care to be completed.

**Proposed Timescale:** 30/03/2016

**Theme:** Governance, Leadership and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The duty roster evidenced that senior clinical staff including the person in charge worked in excess of standard full-time working hours on a consistent basis.

17. **Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
Recruitment of staff is ongoing, since inspection we have successfully interviewed and appointed an assistant director of nursing.

**Proposed Timescale:** 30/03/2016