

**Health Information and Quality Authority
Regulation Directorate**

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



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

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: 26 April 2016 07:30 To: 26 April 2016 20:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Non Compliant - Moderate
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Non Compliant - Moderate
Outcome 08: Governance and Management		Non Compliant - Major
Outcome 12: Notification of Incidents		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care.

Inspectors met with residents', relatives, staff members, and the person in charge. Inspectors tracked the journey of residents' with dementia, and observed the care practices and interactions between staff and residents'. They reviewed documentation such as care plans, medical records and staff files.

The provider had completed the self-assessment and compared the service with the

requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The provider's self assessment found that overall, the centre was in substantial compliance. However, inspectors found moderate and major non-compliances in these same areas. There were significant improvements required in the management of medication and the management of diabetes in order to comply with the regulations and the national standards. These were discussed with the person in charge who was required to take immediate action during the inspection. Furthermore, improvements were identified in the nursing staffing levels in the centre at night time, and in the completion of care plans.

On the day of the inspection there were 70 residents accommodated in the centre. The provider, in her self assessment, estimated that 30 residents had dementia. The residents with a dementia diagnosis are accommodated throughout the centre. At the time of the inspection nearly all of the residents accommodated in the lower ground floor had a diagnosis of dementia and this was the unit inspectors focused on. The premises were generally well-maintained, spacious and clean. However, some issues identified at previous inspections had not been addressed.

Inspectors found that residents had a choice of interesting things to do during the day, with very pleasant interactions with the residents who were unable to participate in activities. The management style of the centre maximized residents' capacity to exercise personal autonomy and choice.

The following outcomes were reviewed as part of the inspection, and the level of compliance is recorded below:

- Health and Social Care Needs : Major non-compliance
- Safeguarding and Safety: Moderate non-compliance
- Residents' Rights, Dignity and Consultation: Substantially compliance
- Complaints procedures: Moderate non-compliance
- Suitable Staffing: Moderate non-compliance
- Safe and Suitable Premises: Moderate non-compliance
- Governance and Management: Major non-compliance
- Notification of Incidents: Moderate non-compliance

There were 20 actions required following this inspection. Twelve of the actions are the responsibility of the provider and eight the responsibility of the person in charge.

Following the inspection, the provider attended a meeting in the Health Information and Quality Authority (HIQA) offices to discuss the non compliances and the action to be taken.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

Inspectors found that residents' healthcare needs were not met by a high standard of evidenced-based nursing care in relation to diabetes management and medicines management. The provision of choice for residents on a modified consistency diet required improvement. There was good access to general practitioner (GP) and allied health services, and suitable systems were in place for the assessment and care planning process.

The management of residents with diabetes required improvement. Inspectors reviewed practices and found inconsistent evidence that the monitoring of blood sugar levels (BSL) using blood glucose meters for residents with type 2 diabetes had been carried out. Inspectors reviewed the records for four residents with type 2 diabetes. Two residents required monthly monitoring of BSL. The records indicated the monitoring of BSL were last completed in January 2016. Two other residents required weekly monitoring of BSL. There were gaps of up to two to three weeks between checks for one resident. The care plans for diabetes did not fully guide practice; for example, the frequency of the BSL checks were not stated, the acceptable levels of blood sugar, and what action to take if the residents was at risk of hypo or hyper glycaemia. The blood sugar level meter could not be located by a nurse on the day of inspection. These matters were brought to the attention of the person in charge who was required to take immediate action. Following the inspection, the person in charge submitted information that all residents with diabetes were seen by their general practitioner (GP), blood tests were carried out and action would be taken to ensure residents with type 2 diabetes were appropriately monitored in accordance with evidenced-based nursing practice.

The medicines management practices in the centre required attention. There was a comprehensive medicines management policy in the centre which was not implemented in practice. An electronic system of medication administration had been introduced in the centre. Inspectors reviewed the prescription and administration records and a number of improvements were identified:

-Residents' medications were not consistently administered at the prescribed time. For example, some medications were prescribed to be administered at 9am. The administration records showed they were given at 11.30am.

-The nurse was not knowledgeable of the use of the electronic system. For example, when asked to see past administration records for the residents, the nurse was unable to demonstrate where the records were located.

-The signature list for nurses was not up-to-date. New nurses recently recruited had not been included in the list.

-There was no space for nurses to record comments if residents' medications were administered late or for to give a reason why.

Inspectors were informed there had been no medication errors in the centre. There were audits completed by the pharmacy service. Records of these were not seen by the inspectors. However, inspectors were told by staff that the issues found above had not been identified in the audits.

The matters in respect to medicines management were brought to the attention of the person in charge. She assured inspectors that training had been provided to staff when the electronic system had been introduced. However, inspectors did not see evidence that staff were familiar with the system in practice. Inspectors requested that the issue be reviewed and following the inspection the provider submitted a satisfactory action plan that would address the issues.

Inspectors reviewed residents' care plans which were held electronically in the centre. There was evidence on some of the residents' files of pre-admission assessments. However, there was no assessment on some files reviewed. A corresponding care plan was in place reflecting the care required by the resident in order to meet their assessed needs. The nursing staff completed evidence based tools to assess residents' clinical needs. The assessments and care plans were updated on a four monthly basis or as the residents' needs changed. However, some care plans did not fully guide practice. For example, weight loss and diabetes management plans.

Inspectors found care plans were updated with recommendations made by allied healthcare team members. For example, the recommendations made by dieticians had been added to the residents' care plan and were being implemented by staff. However, the catering staff had not been provided with the most up-to-date nutritional information. This had also been an action at the previous inspection and was not fully addressed.

Nursing staff told inspectors that they frequently discussed care plans with residents' families and this was confirmed by some family members spoken with. However, there was inconsistent written evidence of the review on some residents' files.

There were procedures in place if residents required to be transferred to hospital or discharged from the centre. The nursing staff informed inspectors that residents who had been transferred into and out of hospital were provided with a transfer letter. While

there were no copies of letters, inspectors were shown the information held electronically for each resident that was used to inform each transfer letter. There were nursing and medical transfer letters sent from the acute hospital back to the centre.

Residents each had a malnutrition risk screening tool (MUST) completed on admission and this was reviewed on a monthly basis. Residents were also weighed and had their body mass index (BMI) completed on a monthly basis. Those with nutritional care needs had a care plan in place and those identified as at risk of malnutrition were referred to a dietician where required. Inspectors saw that residents' likes, dislikes and special diets were all recorded.

Residents who required meals and drinks prepared to a certain consistency had them served as reflected in their assessment. However, choice for residents that required a modified consistency diet required improvement. The menu included choice at mealtimes for residents on normal or an altered consistency diet. However, there was no information on the menu for those prescribed a liquidised diet, and what choice was available for these residents. This was discussed with the chef and the person in charge who told inspectors that action would be taken to update the menu for all residents.

Inspectors spent time in the dining room on the lower ground floor during the lunchtime meal. The menu was displayed on a white board on the wall. Inspectors found the wall menu on the lower ground floor. Inspectors noted the sign may not be fully accessible to all residents (See outcome 12). Residents who required support at mealtimes were provided with timely assistance from staff. Inspectors saw this was provided in a quiet, calm and professional manner.

Residents had access to medical and allied healthcare professionals of their choice. There was written evidence that each resident had a GP of their own choice and a pharmacist. The centre had access to a consultant geriatrician and psychiatrist accessed at the local acute hospital by referral by the resident's GP. There were referrals to allied healthcare professionals and copies of their assessments and recommendations made were available in resident files. An occupational therapist was employed by the centre.

A GP visited the centre up to three days per week. There was evidence that all residents had their medical needs reviewed when required. Inspectors saw evidence on files that residents had been seen at least once per month and had a full medical review within the past year.

An end-of-life policy guided staff practice. Staff had received end-of-life care training. There was access to the palliative care team if required. The majority of bedrooms in the centre were single occupancy. In addition there was one four-bedded room and three two-bedded rooms. The person in charge said that residents would be accommodated in a single room where possible if they were approaching end-of-life.

The social care assessments for residents included their past hobbies, interests and employment history. There were care plans developed for the residents. One-to-one activities listed in assessments reviewed named aromatherapy and hand massage. This omitted one-to-one activities linked with past hobbies, interests and employment history which they potentially may enjoy.

This outcome was judged to be substantially compliant in the self-assessment. However, inspectors judged it as major non-compliant.

Judgment:
Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that there were systems in place to promote the safeguarding of residents and the management of responsive behaviours that challenge. There were some improvements required around the use of restrictive procedures.

There was a policy on the protection of vulnerable adults. It reflected the principals of the Health Service Executive (HSE) Safeguarding Vulnerable Residents at Risk of Abuse, National Policy and Procedures 2014. However, it had not been fully implemented in practice. There had been two allegations of abuse in the centre prior to the inspection. The allegations had been notified to HIQA a number of weeks after they were originally reported. However, they had not been notified within three working days, as required by the regulations. See Outcome 12 on notifications. This was discussed with the person in charge during the inspection. The person in charge assured inspectors she was now fully aware of the requirement to submit an investigation and was familiar with the procedures to be followed.

Inspectors spoke with staff who were familiar with the types of abuse older people could experience, and staff also explained what they would do if they were concerned about a colleague's behaviour. Records that were reviewed confirmed that all staff had received training on recognising and responding to elder abuse. A clinical nurse manager facilitated the training in the centre, which all staff completed on an annual basis.

There were policies in place about the behavioural and psychological signs and symptoms of dementia and restrictive practices. Inspectors were informed by care assistants that they had training in how to support residents with dementia. Training records read for the last three years showed most of the healthcare staff had attended training related to the care of people with dementia. While most nurses had completed training in the past, at the time of the inspection only two nursing staff had been trained in this area. The high turnover of staff in the centre in the previous year had attributed to this, and this is acknowledged by inspectors. This is discussed further in Outcome 5.

Inspectors saw staff dealing with the residents in a calm and dignified manner. Incidents of responsive behaviours were read and these were noted in the documentation. For example, inspectors reviewed a sample of care plans and saw that specific triggers and possible suitable interventions were identified. There was evidence of specialist input when required.

Nurses spoken with were clear that they needed to consider the reasons why people's behaviour changed, and would also consider and review them for issues such as infections, constipation and changes in vital signs.

There was a policy on restrictive practices, which made reference to the national policy "Towards a Restraint Free Environment" 2011. There was evidence that a restraint free environment was promoted, with some work in progress to be made. For example, a recent bedrail record read stated 16 of the 70 residents used bedrails on both sides of their bed. Inspectors found the use of restrictive practices also included alarms for residents at risk of absconding and falls.

The documentation of assessments for the use of bedrails required some improvement. For example, a resident was recorded as having given their consent to the use of bedrails. Later in the same form, the resident is stated as having advanced dementia and is confused at times. It is not clear if the resident gave permission for the bedrails and whether the assessment was correctly completed. Inspectors found there was inconsistent evidence of the alternatives considered or consultation with residents or relatives where required.

This outcome was judged to be compliant in the self-assessment, and inspectors judged it as moderate non-compliant.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found residents could choose how they went about their day, were consulted with about how their day went, their civil and religious rights were respected and they were consulted with about the operation of the centre. There were improvements identified in relation to consultation with the residents and the provision of meaningful activities for some residents with a diagnosis of dementia.

Inspectors observed staff quietly going about their duties on arrival in the centre at 7.30am. The centre was calm and staff respected the residents who were asleep and not yet up. One resident was met in the reception, appearing to be well-dressed.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents with dementia in the lower ground floor sitting room. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record the quality of interactions between staff and residents. The observation took place in one communal area for two one hour periods. The findings of the observational tool are as follows:

The first observation took place in the day room area of the ground floor. The inspector found that 92% of staff interactions with residents during the hour were mainly task-orientated care. Overall, the interaction during these interactions was observed to be meaningful, caring and kind, although the interactions did not move past what was required to get the task at hand complete.

Music quietly played in the room while some residents received one-to-one hand and or head massages. Some residents were being served drinks by staff in a kind way; staff offered choice and took their time when assisting residents. Staff members sat with residents for short intervals to talk to them in a caring and meaningful way. However, some residents sat in chairs receiving little staff interaction for up to 30 minutes. At the end of the observational time, staff played games with the residents. Staff encouraged the residents to be involved in the game and the atmosphere was happy and social.

The second observation took place in the same area, and the inspector found 78% of the hour observed had an overall quality of interaction score of task-oriented care. Residents were listening or watching TV, and some staff were engaged in 1:1 activities with residents. Staff were kind and respectful towards residents and promptly responded to residents' calls for assistance. Staff interactions with residents were friendly. However, the residents were not consistently engaged in any more meaningful conversation and the interactions mainly related to questions about how they were or did they want to go to the toilet.

Staff were observed knocking on bedroom, toilet and bathroom doors before entering if residents were in these rooms. The majority of the residents were seen to be spending time in the communal areas of the centre. Activities were provided in the sitting rooms located on the first and second level by staff who facilitated these. There were limited activities planned for the lower ground level or for residents who preferred to stay in their room or were unable to participate in activities. Many of the activities were provided by the care staff in the unit in-between their main tasks.

There were assessments, resident profiles and a social care plan developed that included detailed information on each resident's assessed needs, likes and interests. The activities provided in the centre included one-to-one time, games, exercise, music, reading.

Residents could access other parts of the building where there were other sitting rooms and a private visitor's room where they could meet with family and friends in private.

However, the garden was not fully accessible. There was a garden directly accessible from the ground floor unit. While the door was open at times during the day, inspectors observed it to be not fully accessible to residents at times of the day. Residents' did not have access to the garden at all times during the day.

Residents' civil rights were respected in the centre. This was discussed with the person in charge. The local county council set up a polling booth at each election in the centre. The person in charge reported this had recently taken place for the general election.

There was information on independent advocacy services displayed in the centre. However, the information was not up-to-date. Furthermore, it was not evident if all residents were informed of the existence of such services. Inspectors discussed this with the person in charge who said the information would be revised and available to residents.

There was an open visiting policy and contact with family members was encouraged. Family members spoken with confirmed they could visit their loved one whenever they wished and there were no restrictions in place.

There was evidence of consultation with the residents and their family members. A residents' committee regularly met and satisfaction surveys were taking place. Inspectors reviewed the committee meetings. There were two resident committees in the centre. It was noted that the committee for residents on the lower ground floor took place with less regularity. For example, two meetings had taken place in 2015. The minutes of the meetings showed that areas discussed, such as staffing levels, meals in the centre and being provided with the minutes of the meetings, were responded to by the provider and person in charge.

Inspectors noted that televisions had been provided in residents' bedrooms. Televisions were also located in communal areas if residents wished to watch them.

This outcome was judged to be compliant in the self-assessment, and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:

There were policies and procedures for the management of complaints however, some improvements were required to comply with the regulations. The complaints policy had been updated in January 2016.

A complaints procedure was prominently displayed in the centre. Inspectors noted that the information in the policy was not in line with the procedures. For example, the nominated person to deal with complaints was different in both documents. This was discussed with the person in charge who informed inspectors that the procedures would be updated to reflect the policy.

The complaints policy stated that all verbal complaints were to be recorded; however this was not fully implemented in practice by staff. For example, verbal complaints were not being recorded in the centre. Inspectors spoke to residents and were informed verbal complaints had been made about various maintenance and premises issues. These were recorded in the maintenance log book, therefore, these complaints could not be tracked or trended. Inspectors spoke to staff who said they were uncertain if verbal complaints needed to be recorded.

A complaints log was reviewed. There had been one recorded complaint in the last two years. It was evident that appropriate action had been taken and the satisfaction of the complainant was recorded.

This outcome was judged to be compliant in the self-assessment, and inspectors judged it as moderate non-compliant.

Judgment:

Non Compliant - Moderate

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:

There was an inadequate number of nurses to meet the assessed needs of residents at night time. The provision of training to staff to meet aspects of residents' care required improvement. There were good systems in place for the recruitment of staff and the provision of mandatory training.

Inspectors reviewed the actual and planned staff roster. There was an adequate number of nurses during the inspection and during day shifts in the centre, with four nurses on duty from 8am until 8pm with up to 16 care assistant staff. However, during the night

time shift, which was from 8pm, there were two staff nurses and five healthcare assistants on duty. These seven staff covered the care of up to 74 residents. On the day of the inspection, of the 70 residents, 19 were assessed as being at maximum dependency with 19 residents assessed as high dependency. Due to the layout of the premises and the dependency level of the residents, the number of nurses on duty at night time is not sufficient. The lower ground floor unit (the former dementia unit) is without the presence of a nurse at nights although assistance is available from the first or second floor. There was evidence of negative outcomes for residents due to the inadequate level of nursing staff at night time as outlined in Outcome 1 (healthcare). This was an issue at the previous inspection and had not been addressed.

The person in charge told inspectors that the centre had experienced a high turnover of nursing staff over the last 12 months. In that time 17 nurses have left employment in the centre. The person in charge said along with the provider, they were actively recruiting new nursing staff and had been successful, but it was work in progress. There were four nurses working in the centre waiting for their registration details to be formalized. In addition, five more nurses were in the process of being recruited. Cover is provided through staff working additional hours and on-call is available in the person in charge and the clinical nurse manager.

There were sufficient numbers of catering and household staff available who were knowledgeable on their respective responsibilities and duties. However, some staff were not aware of the requirement for choice at mealtimes for all residents.

Staff were observed to be friendly and respectful towards residents and were knowledgeable of key operational procedures and policies. However, some improvements were identified as outlined in Outcome 1 and 3.

Inspectors reviewed a training plan for 2016. All staff had up-to-date training in the prevention of elder abuse and fire safety training. Staff had all completed training in the movement and handling of residents. The staff nurses also received additional training in cardiopulmonary resuscitation (CPR) and most nurses had received training in medicines management. However, the implementation of the training in practice was not evident. In addition, nurses had not received training in diabetes care. Following the inspection, the person in charge updated HIQA that all nurses would complete diabetes training and medicines management training in July 2016.

Most of the healthcare assistants have received completed training in dementia care in the past two years. Some nurses had completed dementia training. Due to the turnover of nursing staff, most nurses currently employed had yet to complete this training. The person in charge said there were plans to facilitate training in 2016.

Inspectors reviewed a sample of personnel files for nurses and care assistants in the centre and found them to contain the documentation required by Schedule 2 of the regulations.

A staff appraisal system was in place. This was completed on an annual basis. However, there was no system of staff supervision, as required by the regulations.

A number of volunteers visited the centre, and all had An Garda Síochána vetting in place.

This outcome was judged to be compliant in the self-assessment, and inspectors judged it as moderate non-compliant.

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 design and layout of the centre was in line with the statement of purpose. There were some aspects of the layout of the centre that required improvement to meet the needs of residents with dementia.

Inspectors found the premises met the physical needs of residents at the time of the inspection. For the purpose of the thematic inspection, inspectors spent most of their time in the lower ground floor where the majority of residents had a dementia diagnosis. The centre was well-maintained and in a clean hygienic condition throughout. The centre was homely and decorated to a very good standard. The provider had commenced the implementation of best practice in dementia design in the centre, and this was evident throughout the building. There were interesting things and points of interest for residents in parts of the building and signage provided on some walls and corridors to help residents to find their way

There were some challenges identified in relation to the premises fully meeting the needs of all residents with a dementia diagnosis. It was noted that the menu was on a white board and was not in bright contrasting colours which residents' with dementia may understand. The lettering and pictures used to identify toilets and or direct residents towards various parts of the centre was not consistent throughout. Inspectors discussed this with the person in charge and raised the possibility of using contrasting colours to make toilets and bathrooms more easily identifiable to residents with dementia or a cognitive impairment. Some bedroom doors had photos but not all, to make them more easily identifiable to residents with dementia.

There were sufficient communal dining and sitting areas available for the number of residents accommodated. This included a large living room and dining room on the lower ground floor. There was a main dining room on the ground floor. In addition, there were two sitting-cum-dining rooms on the upper floors, a large dining room, a private sitting room and a number of sitting areas. The house was nicely furnished in a homely manner. In some communal areas around the centre there were points of

interest for residents with dementia to encourage them to engage with or explore their environment. In some hallways where there are none, this could be explored further.

The centre is a three storey building over a basement structure. The residents are accommodated on three floors. Level one is in the basement, level two is on the ground floor and level three is on the first floor. The fourth floor is used for administration purposes only. Facilities included suitably adapted shower toilets and bathrooms, the number of which was in compliance with the standards. There is a well-maintained garden accessible from the centre for the residents.

Level one is a 15 bedded unit; it had previously been a dementia specific unit. Inspectors spent most of the inspection in this unit as nearly all residents have a dementia diagnosis.

Twenty one residents are accommodated on level two. There are 20 single rooms, 11 of which have en-suite sink and toilet. There is one two-bedded room. There are three assisted toilets and or shower rooms on this level.

Thirty six residents reside on level three, which consists of 29 single rooms; 10 of which have en-suite sink and toilet. There is also two two-bedded rooms and one four-bedded room on this level.

The bedrooms were spacious and there was room for chairs, furnishings and any assistive equipment required. The three- and four-bedded room were provided with a screen between all beds.

A suitable and safe garden is available and easily accessible off the lower ground floor. It was unlocked at times during the inspection however, inspectors observed the door to be locked for an hour in the afternoon. A resident who approached the door at this time was unable to open it.

The actions arising from the previous inspections had not been fully addressed:

1. Adequate light in a number of bedrooms and the day room on the lower ground floor unit which was partially blocked by an external wall
2. A four-bedded room on the second floor does not meet the National Standard requirements. The residents in the bedroom do not receive 24 hour high support nursing care.

This outcome was judged to be compliant in the self-assessment, and inspectors judged it as moderate non-compliant.

Judgment:

Non Compliant - Moderate

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:

Inspectors found there was insufficient governance and resources to ensure the effective delivery of care to residents in the centre. Furthermore, systems in place to review the quality and safety of care provided to residents in the centre required improvement. There was a clearly defined management structure in place, with clear lines of authority and accountability.

The centre is operated by Lucan Lodge Nursing Home Limited. There was a clearly defined management team which included the person nominated on behalf of the registered provider (who for the report is referred to as the provider) and the person in charge. The person in charge reported to the provider who was also based full-time in the centre. Inspectors saw the minutes of clinical governance meetings. The minutes of the last meeting were dated 14 December 2015; there was no evidence of other meetings since then.

There were some systems in place to ensure the service provided to residents were effectively monitored however, these required improvement. There was weekly gathering of key performance indicators such as: pressure sores, restraint, wounds, weight loss and complaints, which were reviewed by the person in charge. However, no other clinical audits were completed of care practices in the centre, for example, staffing levels, medication management practices, diabetes and mealtime experiences, therefore it could not be ascertained if any improvements or learning were required in these areas.

Therefore the governance and management systems in place did not ensure the care and practice in the centre was appropriately and consistently monitored to enable compliance with the regulations as supported in findings of this inspection in Outcome 1 (health and social care needs) and Outcome 5 (workforce). As reported earlier, the provider submitted an action plan after the inspection that outlined the improvements they would bring about to come into compliance.

Judgment:

Non Compliant - Major

Outcome 12: Notification of Incidents**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

Findings:

As reported in Outcome 2 (safeguarding), allegations of suspected abuse were not notified to HIQA within three working days.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Lucan Lodge Nursing Home
Centre ID:	OSV-0000061
Date of inspection:	26/04/2016
Date of response:	22/06/2016

Requirements

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

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

Outcome 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:

There was inconsistent evidence of admission assessments on residents' files.

1. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the

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

person's admission to the designated centre.

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

All residents pre-assessments are in residents files within the nurses' station and will be kept there in the future

Proposed Timescale: 22/06/2016

Theme:

Safe care and support

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

The care plans for some residents did not fully guide practice. For example, weight loss and diabetes management.

2. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

All care plans have been reviewed and updated to include diabetes management and weight loss. These are included in our Audits and also included in our weekly review meeting. This is followed up by CNM 2 after weekly meeting making sure that the changes have been added to Care Plan.

Proposed Timescale: 22/06/2016

Theme:

Safe care and support

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

A high standard of nursing care was not provided to residents' in the management of diabetes and medication management,

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 Cnáimhseachais.

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

4 residents who have challenging behaviour and who had refused to cooperate with blood sugar monitoring did not have consistent BM checks which the GP's were fully aware but unfortunately this was not noted on their file. There is now a directive in place from GP's and it is also recorded in their care plan. There is now a new diabetic policy in place which guides practice. All diabetics are reviewed weekly and we also

have a new audit tool. Every person with diabetes has a plan for 3 monthly review of HbA1c.

Proposed Timescale: 22/06/2016

Theme:

Safe care and support

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

Residents' on a liquidised diet were not offered choice at mealtimes.

Menus did not include the meals or the range of choices available for these residents'.

4. Action Required:

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

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

All residents on liquidised diets now have a choice of 10 meals and 5 deserts daily which are on a separate menu. Care staff completes a menu as per residents preferences and this sent to the kitchen daily. Responsibility for implementation will be head chef and PIC or her deputy.

Proposed Timescale: 04/07/2016

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 copy maintained of a transfer letter when residents' were temporarily admitted to an acute hospital.

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:

A copy of any transfer letter in downloaded printed and kept on file.

Proposed Timescale: 22/06/2016

Theme:

Safe care and support

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

The administration of residents medications was not in accordance with the time prescribed by the medical practitioner.

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:

We introduced a electronic medication management system late last year and all staff had training prior to implementation, unfortunately our auditing system with the pharmacy failed to pick up on lack of in depth knowledge of staff. We have temporarily suspended using this system until further training takes place.

All staff nurses have been re-educated regarding the importance of administering medications on time. Training took place on the 20/04/2016 and was provided by a Pharmacist from Median Healthcare and all staff are undertaking online medication management with HSELand. We also have introduced our own medication management audit which includes on the spot assessment of nurses knowledge.

Diabetes training took place on the 2nd and 7th of June and was provided by a dietitian from Nualtra. All nurses have completed on line training with Abbott nutrition

Proposed Timescale: 22/06/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

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

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

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

7. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

All alternatives tried are now included on assessment.

On admission some resident request bed rails as a safety precaution.

Re assessment will take place as residents condition deteriorates in consultation with the family and taking into consideration the residents previous request.

Proposed Timescale: 22/06/2016

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:

The provision of meaningful activities for residents' with a dementia and who were unable to take part in activities, required improvement.

8. Action Required:

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

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

Our O.T is working on updating our activity programme, activity board and notice board We have an extensive plan which has already started. Work has commenced on phase 1 of 3 phase plan. Phase 1 includes educating the staff and getting them to recognise that all activity can be a meaningful interaction, and encouraging staff to be proactive and use the knowledge and skills which they already have to gain a positive outcome Attached to this report is the full 3 phase plan developed by our O.T. Staff education to take place on 23rd of June but the O.T has already liaised with staff.

Proposed Timescale: 31/03/2017

Theme:

Person-centred care and support

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

Information on independent advocacy services was not up-to-date or demonstrated to be offered to residents'.

9. Action Required:

Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

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

SAGE advocacy are coming in on the 8th July for afternoon tea for all residents and their families. This is an initial meeting to introduce themselves and their services. Going forward SAGE will be hosting our residents council meetings, and they will generate a report and send to the PIC for an action plan if required.

All this information for residents and families is on the notice board. Staff have been educated regarding advocacy services.
SAGE are providing support to 3 of our residents in dealing with social, financial and legal issues.

Proposed Timescale: 08/07/2016

Theme:

Person-centred care and support

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

The regularity of resident meetings' in the lower ground floor unit requires review.

10. 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:

SAGE advocacy are coming in on the 8th July for afternoon tea for all residents and their families. This is an initial meeting to introduce themselves and their services.

Going forward SAGE will be hosting our residents council meetings, and they will generate a report and send to the PIC for an action plan if required.

All this information for residents and families is on the notice board. Staff have been educated regarding advocacy services.

SAGE are providing support to 3 of our residents in dealing with social, financial and legal issues.

Proposed Timescale: 08/07/2016

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

The complaints policy and procedure named different staff as the nominated person to deal with complaints.

11. Action Required:

Under Regulation 34(1)(c) you are required to: Nominate a person who is not involved in the matter of the subject of the complaint to deal with complaints.

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

Complaint policy and procedure updated.

Proposed Timescale: 22/06/2016

Theme:

Person-centred care and support

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

There was no record of verbal complaints in the centre.

12. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

Verbal complaint books are now available in every nurse station and staff have been educated around same.

The complaints officer is Filipe Cura. All documentation has been updated to reflect same.

Proposed Timescale: 22/06/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

There was an inadequate number of nurses to meet the assessed needs of residents' at night time.

13. 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:

We have endeavoured to increase the night staff nurse numbers over the past year but due to staffing crisis have not be able to do this in a consistent manner. We have a CNM1 on night duty from the beginning of June and have 5 nurses waiting on their pin numbers already working in the nursing home. We would hope to have a full complement of staff nurses by Oct 2016. Once these nurses get their pin numbers we will immediately put 3 nurses on night duty.

We are continually trying to recruit nurses who have their registration and will continue to do so in an effort to increase staff nurse levels.

Plan to date ; CNM 1 on night duty and until we can have 3 nurses working night duty we have increased carer numbers to 6
The CNM 1 is giving Management weekly reports and supervising the night routine.

Proposed Timescale: Plan to date : complete JUNE 2016
Still waiting on registration for our nurses OCT 2016

Proposed Timescale: 30/10/2016

Theme:
Workforce

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

Nursing staff did not have appropriate training the care of residents' with diabetes.

14. 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:

Diabetic training is taking place on 2nd and 7th of June and all staff are in the process of completing online training regarding diabetes management

Proposed Timescale: 01/08/2016

Theme:
Workforce

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

There was no system of staff supervision in the centre.

15. Action Required:

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

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

We now have CNM1 nurses on day duty who oversee and all care with the back up of the CNM2.

The PIC and her deputy are completing audits and assessment tools to supervise that staff are carrying out their work to a high standard.

Proposed Timescale: 22/06/2016

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:

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

16. Action Required:

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

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

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

Proposed Timescale: 31/12/2017

Theme:

Effective care and support

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

A four bedded room in the centre will not meet the National Standards.

17. Action Required:

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

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

As stated in previous correspondence this work will have to be completed from cash flow and will be finished prior to revised deadline. The room will be divided into 2 two bedded units with screens dividing room for privacy and dignity and a sink, wardropes etc

Proposed Timescale: 31/07/2021

Theme:

Effective care and support

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

The use of best practice design dementia care facilities should be further explored to meet the needs of all residents' in the centre

18. 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:

The décor and design for residents with a diagnosis of dementia is been reviewed

Proposed Timescale: 01/09/2016

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:

The management systems in the centre did not ensure residents' needs were consistently and effectively monitored and require improvement.

19. Action Required:

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

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

There was a clinical governance meeting held on 25th April 2016 but the minutes had not been entered into the folder which was given to the inspector.

We have completed 19 clinical audits so far this year these include wound, communication, continence, personal care, nutrition, infection control, challenging behaviour to name but a few as per our policies. These are reviewed on a 1 monthly, 3 monthly or 6 monthly basis depending on percentage scored.

We also have residents and family surveys which include care, nutrition and quality of service. The kitchen staff also complete a survey which is focused on food choice quality and service.

All audits and surveys were provided to inspectors on day of visit.

We have a new diabetes policy and audit tool.

We have a new medication management audit tool, which will be done in conjunction the the Median Healthcare audit.

We have 3 new clinical nurse managers working during the day who attend weekly meeting with the PIC and her deputy.

Proposed Timescale: 22/06/2016

Outcome 12: Notification of Incidents

Theme:

Effective care and support

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

Allegations of suspected abuse had not been notified to HIQA within three working days.

20. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

We were focused on investigating allegation and failed to notify HIQA in the 3 day time line.

Obviously we are aware of the importance of notifications.

Proposed Timescale: 22/06/2016