<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Thomond Lodge Nursing Home</th>
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<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000109</td>
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<tr>
<td><strong>Centre address:</strong></td>
<td>Ballymahon, Longford.</td>
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<tr>
<td><strong>Telephone number:</strong></td>
<td>090 643 8350</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:info@thomondlodge.com">info@thomondlodge.com</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Thomond Care Services Limited</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Sean Kelly</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Mary O'Donnell</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Leanne Crowe</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>47</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>1</td>
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</table>
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.
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: 07 September 2016 07:30  
To: 07 September 2016 19:00

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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</thead>
<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>Substantially Compliant</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 08: Governance and Management</td>
<td></td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

**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. The inspection also followed-up on progress with the completion of action plans required to address non-compliances with the regulations from two focused inspections in 2015. An inspection on 27 October 2015 focused on wound care and the seven related action plans were found to be completed. The inspection on 18 June 2015 focused on medication management and falls prevention. Three of the six related action plans were completed. Some action plans relating to care plans, falls prevention and medication management were not completed and are restated at the end of this report.

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The inspection also followed-up on
progress with the completion of action plans required to address non-compliances with the regulations from two focused inspections in 2015. An inspection on 27 October 2015 focused on wound care and the seven related action plans were found to be completed. The inspection on 18 June 2015 focused on medication management and falls prevention. Three of the six related action plans were completed. Some action plans relating to care plans, falls prevention and medication management were not completed and are restated at the end of this report.

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

Prior to the inspection, the person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the Revised National Quality Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the self-assessment and inspectors’ rating for each outcome.

Inspectors met with residents, relatives and staff members during the inspection. They tracked the journey of four residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff rosters and training records.

Thomond Lodge is registered for 48 places. On the day of inspection 25 of the 47 residents had dementia, 13 of whom had a formal diagnosis. The centre does not have a specific dementia care unit. The purposed built centre was maintained to a high standard and suitable for its stated purpose. Aspects of the physical environment were designed to support residents with dementia. The management and staff of the centre were striving to create a change in their culture of care, aiming to fully move away from a task driven model of care to a fully person centred approach. Residents appeared well cared for and expressed satisfaction with the care they received in the centre and confirmed that they had autonomy and freedom of choice. Residents spoke positively about the staff that cared for them.

Staff turnover was high and the six nurses had left the service in the previous year had only recently been replaced. Consequently the person in charge had focused on nursing duties and had neglected aspects of her role as person in charge. Quarterly audits were not completed and there was no analysis of falls undertaken to improve outcomes for individual residents or to inform service improvements. Mandatory staff training and refresher training had not been completed. 11 staff had not attended refresher training in safeguarding and four staff did not have Garda Clearance. The person in charge took immediate action to address this and submitted written assurances to the Chief Inspector that all staff working in the centre had Garda Clearance.
Although the activity co-ordinator worked full time from Monday to Friday, there was still only one person available to assess residents’ social needs and deliver activity programmes. Inspectors found that the social needs of some residents especially residents with advanced dementia were not met. During the formal observation period inspectors observed some staff interacting in a positive person centred way with residents. However the majority of interactions between staff and residents were scored as neutral or negative protective and controlling care practices. Dementia care training had been provided an more training was planned for later in September. The management and staff of the centre were working to create a change in their culture of care, aiming to fully move away from a task driven model of care to a fully person centred approach. Residents appeared well cared for and expressed satisfaction with the care they received in the centre and confirmed that they had autonomy and freedom of choice. Residents spoke positively about the staff that cared for them.

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.
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:**
This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3

There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Comprehensive assessments were carried out and care plans developed based on the assessments. Care plans were reviewed at a minimum on a four monthly basis but the care plan reviews were not comprehensive and did not always reflect the changing health status of a resident. In the case of a resident who was tracked; their care plan referred to a period when they were mobile even though the resident was confined to a chair and no longer mobile. Residents and their families, where appropriate were involved in developing care plans but not in the care plan review. This was also a finding on the previous inspection. None of the care plans examined held end of life care plans which reflected the wishes of residents with dementia. Improvements were required to ensure that residents were protected by safe medication policies and procedures.

Residents had timely access to the medical services and were supported to retain the services of their own general practitioner (GP), if they wished to do so. They had access to allied healthcare professionals including occupational therapy, dietetic, speech and language, ophthalmology and podiatry services. The centre also had access to the mental health and palliative care services. However physiotherapy services were limited and residents with natural teeth did not have routine dental assessments.

Inspectors focused on the experience of residents with dementia and they tracked the journey of four residents with dementia. They also reviewed specific aspects of care such as nutrition, wound care and end of life care in relation to other residents.

There were systems in place to optimise communications between the resident/families, the acute hospital and the centre. The person in charge visited prospective residents in hospital prior to admission. This gave the resident and their family information about the
centre and also to ensure that the service could adequately meet the needs of the resident. Residents’ files held a copy of their hospital discharge letter with relevant information and residents who were transferred to hospital from the centre had appropriate information about their health, medications and their specific communication needs were included with the transfer letter.

Residents had a comprehensive nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident’s dependency level, risk of malnutrition, falls, and their skin integrity. A care plan was developed within 48 hours of admission based on the residents assessed needs. Care plans contained the required information to guide the care of residents, and were updated routinely on a four monthly basis or to reflect the residents' changing care needs. The ‘key to me’ was used to support residents and relatives, where appropriate to inform their assessments and the care plans. However not all the files reviewed held a completed ‘Key to me’ document. There was no documentary evidence that residents and family where appropriate participated formally in care plan review meetings.

Staff provided end of life care to residents with the support of their medical practitioner and the community palliative care services if required. However staff did not discuss future care needs or end of life wishes with residents in order to develop care plans which reflected the residents' preferences for care including their preferred setting for delivery of care. Single rooms were available for end of life care and relatives were accommodated in to stay with residents who were very ill. Systems in place to prevent unnecessary hospital admissions, included timely medical review and early referral to palliative care team. Two residents had been reviewed by the community palliative care team at the time of inspection.

Inspectors tracked wound care for two residents and found their wounds were either healed or healing. Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing. The incidence of pressure related wounds was low.

Residents with diabetes were appropriately monitored and managed. Inspectors found the staff who undertook the procedure adhered to the HIQA guidance of blood glucose monitoring.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. However residents who gained weight unintentionally required support to maintain a healthy weight. Residents were reviewed by the dietician and the care plans reflected the specialist advice, however there was no oversight to ensure that the care plans were communicated to staff and implemented. Inspectors saw a resident who was on a weight reducing diet being offered butter with their dinner by two separate staff members. Despite continued weight gain this resident’s care plan was not reviewed.
Inspectors found that residents on diabetic, and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served. The social aspect of mealtimes would be enhanced if staff sat with the residents while providing encouragement or assistance with the meal. A resident who had a percutaneous endoscopic gastrostomy (Peg tube) had a care plan which directed the resident’s care in relation to the management of the tube, rest periods and the feeding regime.

The arrangements in place to review accidents and incidents within the centre required improvement. Residents were regularly assessed for risk of falls and those at risk had a care plan in place. Incident forms were completed following a fall but they were not analysed to determine what factors, if any could be adjusted to minimise the risk of another fall or injury from a fall. Residents did not have a medication review or a physiotherapy review following a fall. A resident who fell and sustained a head injury did not have neurological observations done. Although falls rates for individual residents were referenced in the annual review the person in charge did not collate statistics on falls to monitor trends and there was no data available on the overall incidence of falls in the centre.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were implemented for the residents who were case tracked. Inspectors found that practices in relation to prescribing and medication reviews met with regulatory requirements and staff were observed to follow appropriate administration practices. Residents had access to the pharmacist. Inspectors followed up on action plans from the previous inspections and found that appropriate procedures for nurses to transcribe prescriptions into the medication kardex had been reviewed and they now included the date when prescriptions were transcribed along with a doctor's signature to signify that the medical officer was satisfied that the transcription was correct.

Residents on warfarin were protected by two nurses witnessing the dosage being administered. However there was no documentary evidence that a second nurse listened to the prescribing instructions delivered by telephone as required by the policy or with guidelines issued by An Bord Altranais agus Cnáimhseachais. Inspectors noted that the date when eye drops and creams were opened was not recorded on medications stored in the fridge. The temperature of the medication fridge was recorded daily. Records showed that a temperature of 1°C was recorded on three occasions which is below the recommended setting.

**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):**
No actions were required from the previous inspection.

**Findings:**
Measures in place to protect residents from abuse were found to be inadequate. Not all staff had attended training on the prevention, detection and response to abuse. Training records showed that 11 staff had not attended training since 2012 and the majority of staff had not had refresher training to update them in relation to the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse (2015).

Staff who spoke with inspectors were knowledgeable about the various types of abuse and were familiar with the reporting structures in place. However inspectors were made aware of three incidents which merited investigation to out rule of peer to peer abuse. Two separate incident reports stated that following a hostile action by one resident another resident fell to the ground and required assistance from staff. Neither the person in charge nor the staff member had considered that these residents had been physically abused.

Four recently recruited staff did not have Garda Clearance on file. The person in charge took immediate action to rectify this and the next day she submitted written assurances to the Chief Inspector that all staff working in the centre had Garda Clearance.

The provider acted as an agent for three residents and managed small amounts of money for a number of other residents. Inspectors saw that there was a clear, transparent system in place where all transactions were documented. Lodgements and withdrawals were signed by the accounts manager and the resident or a staff member. Receipts were held on file and the amounts in safekeeping were checked with the records and found to be correct.

There was a policy and procedures in place that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). Residents with significant behaviours that challenge were not admitted to the centre and when changes in behaviour occurred staff were guided by the policy to first out rule any underlying physical, emotional or environmental cause. In the case of one resident who was tracked this resident had a formal assessment undertaken prior to being assessed by the psychiatry of later life team. A care plans was put in place to direct care and promote a consistent approach to care. Interventions such as reassurance that the farm animals were being looked after and a phone call to a son trailed before medication was given. It was evident that physical or chemical restraint was used only as a last resort. Incidents where restraint was used were appropriately notified to the Authority. Concerted efforts were made to promote a restraint free environment and bed rail use had been reduced to 15%. There was evidence that less restrictive devices were used such half length bed rails and sensor mats. These measures achieved the goals of care without restricting the residents’ freedom.

**Judgment:**
Non Compliant - Major

**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:**
While inspectors were satisfied that residents' privacy and dignity were respected for the most part, some improvements were required regarding staff interactions with residents and ensuring that the activities available to residents with dementia reflected the capacities and interests of each resident.

There was a full-time activity co-ordinator dedicated to providing facilities for occupation and recreation for residents during the week. A dedicated care staff member was rostered to facilitate activities at weekends. In addition to activities held in the centre, outings were organised to local events and areas of interest during the year. There was evidence that such outings had been chosen in collaboration with residents, and that residents were satisfied with activities that were arranged. A number of group activities occurred in the centre on the day of the inspection; however, there was little evidence of one-to-one activities, for residents who were unable or unwilling to participate in groups. A 'Key to Me' document containing information about each resident's history, hobbies and preferences was used to inform the planning of activities. However on the day of the inspection, a number of these documents had not been fully completed for residents with dementia. The assessment did not consistently reflect the current capacities or preferences of residents. Improvements are required to ensure that residents with dementia participate in activities that promote engagement and are informed by their capacities and interests.

Further improvement was needed to ensure that staff engaged meaningfully and respectfully with residents at all times. Inspectors spent two hours observing staff interactions with residents, including those with dementia. These periods of observations took place in the dining room and day room. Records of the quality of interactions between residents and staff indicated that 35% of interactions demonstrated task orientated care, 30% of interactions demonstrated neutral care and 35% of interactions demonstrated protective and controlling care. This was discussed with the person in charge on the day of the inspection, who committed to putting an improvement plan in place.

There was evidence to support that residents with dementia received care in a dignified manner that respected his or her privacy. However inspectors found that less able residents who were unable to lock the toilet door were sometimes disturbed by other residents. Signage to indicate that the toilet was in use should be considered. Staff were observed knocking on residents' bedroom doors before entering, and the centre had restricted visitors from entering residents' sleeping areas in the morning, to maintain privacy for all residents. There were no restriction on visiting times, there were facilities to allow residents to receive visitors in private, and residents could undertake personal
activities in private.

There was evidence that feedback from residents with dementia were consulted about how the centre is run, and the services that are provided. Residents' meetings were held every 2-3 months, with minutes of these made available for inspectors to read. The minutes indicated that a substantial number of residents with dementia frequently attended these meetings. Relatives of residents were also in attendance. Inspectors observed that the bedrooms of residents with dementia were personalised with furniture and possessions.

The centre had developed a number of methods of maintaining residents' links with their local communities. A number of residents attended the day centre a short distance from the nursing home, and outings to residents' localities were frequently arranged. Eight priests from the residents' own parishes visited the centre to hold religious services on an alternating weekly basis. Phones were installed in each bedroom, and two computers also had Skype facilities, which residents availed of. Daily and local newspapers were provided for residents.

Residents were facilitated to exercise their civil, political and religious rights. There was evidence that residents' right to refuse treatment or care interventions was respected, and that residents were facilitated to vote in the centre or in their respective localities. Residents were satisfied that they had opportunities to practice their religion.

Communication plans were in place to support residents, specifically those with dementia, and inspectors observed staff adhering to these in practice for the duration of the inspection. Inspectors found that residents with hearing impairments would benefit if staff had additional training about the upkeep of hearing aids. This was discussed at the feedback meeting.

Residents had access to an advocate, should they require such services.

**Judgment:**
Substantially Compliant

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<th><strong>Outcome 04: Complaints procedures</strong></th>
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<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
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**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There was a policy and procedure in place for the management of complaints, but improvement was required to ensure that verbal complaints were being recorded, in line with the centre's policy.
The complaints policy stated that verbal complaints should be recorded, however there was no evidence to support that this was carried out.

The person in charge actively encouraged residents and families to give feedback to staff. Staff who spoke with inspectors explained what they would do should they receive a complaint and how they would assist a resident to make a complaint.

The policy was found to contain details of the person nominated to manage complaints and the person nominated to ensure complaints were recorded and responded to appropriately. The appeals process was also clearly outlined. While a copy of the complaints process was displayed at the entrance to the centre, the format did not ensure it was accessible to all residents, particularly those with dementia.

Inspectors examined the complaints log, which contained details of the investigation into the complaint, the outcome of the complaint, and the satisfaction of the complainant with the outcome. Complaints were seen to be closed out promptly.

**Judgment:**
Substantially Compliant

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### Outcome 05: Suitable Staffing

**Theme:**
Workforce

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

**Findings:**
While there were appropriate staff numbers in the centre on the day of the inspection a review of staffing was required and systems improved to ensure staff were appropriately trained, and that staff and volunteers are recruited, selected and vetted in accordance with best recruitment practice. Garda clearance was not on file for new staff, this is discussed further in Outcome 2. In addition the roles and responsibilities of volunteers were not set out in writing, as required by the Regulations.

An actual and planned roster was made available to inspectors, and reflected the levels of staff on duty in the centre on the day of the inspection. Inspectors recommended a review of staff levels for the following reasons:
*The current staffing compliment does not reflect the WTE staff compliment outlined in the Statement of Purpose.*
*The person in charge had to undertake nursing duties and was unable to take the administration days required to fulfil her role as person in charge.*
*The person in charge stated that the six nurses who left the service were being replaced by four nurses.*
*On Saturday and Sunday a care assistant was delegated to cover for activity provision, but the roster did not reflect that any additional resource to meet the additional*
demand.
*Relatives who spoke with inspectors expressed concerns about staffing levels at the weekend.

There was a training programme in place for staff; however, training records indicated that all staff had not completed up-to-date mandatory training as required by the Regulations. Inspectors observed good manual handling practices and found that all staff were up-to-date with training in moving and handling practices. Staff had received training in fire safety; however inconsistent accounts of evacuation procedures were given by some staff on the day of the inspection. The person in charge stated that training in fire safety was schedule for the week after the inspection. A number of staff had not attended training in the prevention, detection and response to abuse in the last two years; however the majority of staff had not received training since 2012 or 2013. This is discussed in further detail in Outcome 2.

Some staff required further training to improve their skills in order to provide person centred care. During the formal observation period inspectors observed some staff interacting in a positive person centred way with residents. However the majority of interactions between staff and residents were scored as neutral or negative protective and controlling care practices. Staff who spoke with inspectors were not sufficiently informed about supporting residents who required hearing aids.

A robust induction programme was in place for newly recruited staff, which included periods of supervision and a 3 month review. Annual staff appraisals were ongoing for this year, with action being taken where training needs were identified.

The person in charge held meetings for the various levels of staff on a frequent basis and meetings for the whole staff complement occurred twice annually. Staff spoken with on the day of the inspection all felt supported by the centre's management team.

**Judgment:**
Non Compliant - Moderate

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**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 purpose built single story nursing home is situated close to the town. The location, design and layout of the centre is suitable for its stated purpose and met residents’ individual and collective needs in a comfortable and homely manner. The inspectors found the centre to be warm, well maintained and suitably decorated. Residents had good access to indoor and outdoor areas and to external gardens with
raised flower beds and seating areas. The grounds were well maintained. Sitting and dining rooms were spacious enough with good natural lighting and were decorated in a homely and warm fashion.

There was ample communal space including a day room, a dining room a library and a recreational room with a TV and computers for residents use. There was a small oratory, a smoking room and a hairdressing salon on site. Residents in each suite also had access to a secure well maintained outdoor area.

Corridors and door entrances used by residents were wide and spacious to facilitate movement and aids used and required by residents. Matt flooring throughout helped to minimise glare and was suitable for people with dementia. There were plenty of seating bays where residents congregated. Bedrooms were spacious to accommodate personal equipment and devices required by existing residents. Handrails and grab rails were provided where required in circulating areas and in bathrooms. Bedroom accommodation was provided with single room accommodation with a large en suite shower, toilet and wash hand basin. The contrasting blue flooring and grab rails supported optimal functioning for residents with dementia. All bedrooms had an accessible call bell and a telephone by the bedside and many of the residents had clocks and calendars in their bedrooms. Bedrooms in all four suites had views of the garden.

Inspectors were informed that the staff had made progress towards creating a dementia friendly environment and this was apparent on the inspection. Examples of this include symbols and signage to orientate residents and most of the bedrooms were personalised to suit the individual resident.

Further improvements were discussed with inspectors such as reviewing the level at which signs were placed on the walls and the further use of contrasting colours.

**Judgment:**
Compliant

**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The quality of audits was an issue on the inspection in June 2015. Inspectors found that this was a recurring issue on this inspection. The person in charge told inspectors that she did not have the time required to complete the action plan. Staff turnover was high and the six nurses had left the service in the previous year had only recently been replaced. Consequently the person in charge had focused on nursing duties and did not have the protected two days each week required to fulfil her role as person in charge.
Quarterly audits were not completed and there was no analysis of falls undertaken to improve outcomes for individual residents or to inform service improvements.

The matrix for staff training had not been updated with the names of recently recruited staff and mandatory staff training and refresher training for existing staff had not been completed. 11 staff had not attended refresher training in safeguarding. Applications had been made for staff to be Garda Vetted however four new staff were rostered before they had Garda Clearance. The person in charge took immediate action to address this and submitted written assurances to the Chief Inspector that all staff working in the centre had Garda Clearance.

The inspectors held the view that the non compliances found on this inspection related to the failure to put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored. The person in charge told inspectors that that this would be addressed now that the staffing resource issues had been resolved.

**Judgment:**
Non Compliant - Moderate

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**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:**

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

Centre name: Thomond Lodge Nursing Home
Centre ID: OSV-0000109
Date of inspection: 07/09/2016
Date of response: 04/10/2016

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 evidence that residents and family where appropriate participated in the assessments and development of care plans. However there was no documentary evidence of their involvement in care plan reviews. Inspectors found that care plans were not comprehensively reviewed.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
We will ensure that family members where possible shall be involved in the revision of care plans and same shall be documented when reviewed no less than 4 monthly.

Proposed Timescale: 19/09/2016

Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident had sections which were not completed and the other resident’s ‘Key to me’ was blank.

2. 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 person’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
All ‘Key to Me’ shall be completed as part of the admission process. All additional information shall be recorded in a timely manner.

Proposed Timescale: 19/09/2016

Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have a medication review or a physiotherapy review following a fall. A resident who fell and sustained a head injury did not have neurological observations done.

3. 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:
Medication and physiotherapy reviews will be carried out all residents following a fall. All residents who sustain a head injury shall have neurological observations carried out.
Proposed Timescale: 19/09/2016

Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents with natural teeth did not have a routine dental check up.

4. Action Required:
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
We are in the process of liaising with our local dentist with a view to putting in place a system of regular reviews in house for all residents.

Proposed Timescale: 19/09/2016

Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
None of the files reviewed held 'End of life' care plans that outlined the physical, psychological and spiritual needs of the residents, including residents' preferences regarding their preferred setting for delivery of care.

5. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
All end of life care plans shall be reviewed and updated to ensure they include all aspects of end of life focusing on the physical, emotional, social, psychosocial and spiritual needs. Also including their preference of where they wish to be cared for.

Proposed Timescale: 19/09/2016

Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement
Residents who gained weight unintentionally required support to maintain a healthy weight.

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

Please state the actions you have taken or are planning to take:
Closer attention will be paid to weight gains and a better plan will be put in place to provide assistance to staff to enable and encourage residents who are gaining excess weight to reduce same. Families shall be informed of the importance of their co-operation in achieving the desired results. Kitchen staff and carers will continue to be educated and updated on nutrition and dietary needs of all residents.

Proposed Timescale: 19/09/2016

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 documentary evidence that a second nurse listened to the prescribing instructions delivered by telephone as required by the policy or with guidelines issued by An Bord Altranais agus Cnáimhseachais.
*The date when eye drops and creams were opened was not recorded on medications stored in the fridge.
*The temperature of the medication fridge was recorded daily. Records showed that a temperature of 1°C was recorded on three occasions which is below the recommended setting.

7. 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:
Policy has been amended to instruct nurses of the guideline requiring 2 nurses to listen to prescribing instruction with regard to warfarin and document same.

Nurses have again been educated on the requirement of signing dates on creams, eye drops and insulin.

Engineer has been contacted to carry out a service on the medication fridge and staff have again been informed that the correct temperature for the fridge is 2-8 °C and to
report any abnormalities outside this range to maintenance immediately.

**Proposed Timescale:** 19/09/2016

### 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:**
Training records showed that 11 staff had not attended training since 2012 and the majority of staff had not had refresher training to update them in relation to the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse (2015).

**8. Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
All staff who have not undergone training in 'Safeguarding Vulnerable Persons at risk of Abuse in the last twelve months shall have refresher training before the end of this year. We shall ensure that all training is kept up to date.

**Proposed Timescale:** 30/12/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Four recently recruited staff had applied for Garda clearance but their application had not been processed.

**9. Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Three of the garda vettings which were in the process of being vetted at the time of inspection are now complete and have been returned by the vetting bureau. The one outstanding member of staff is not rostered at present and shall remain so until vetting has been returned.

**Proposed Timescale:** 19/09/2016
**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors were made aware of three incidents which merited investigation to out rule of peer to peer abuse. Two of the incidents were reported but neither the person in charge nor the staff member had considered that a resident may have suffered abuse.

10. **Action Required:**
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:
All incidents and allegations of abuse shall be investigated and recorded and staff re-educated in elder abuse with focus on peer to peer abuse.

*Proposed Timescale: 19/09/2016*

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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 limited evidence that the activities available reflected the capacities and interest of each individual resident with dementia.

11. **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:
Since the date of inspection 9 staff, including 4 care assistants have attended a course in the quality of life from persons with dementia which had a specific focus on activities for those with dementia. Further courses in dementia training have been arranged for the coming months.

*Proposed Timescale: 19/09/2016*

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**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:
Ensure that verbal complaints are recorded appropriately, in line with the centre's complaints policy.

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:
All staff have been made aware that all complaints including verbal complaints must be recorded and followed through in accordance with our policy.

Proposed Timescale: 19/09/2016

Outcome 05: Suitable Staffing
Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors recommended a review of staff levels for the following reasons:
*The current staffing compliment does not reflect the WTE staff compliment outlined in the Statement of Purpose.
*The person in charge had to undertake nursing duties and was unable to take the administration days required to fulfil her role as person in charge.
*The person in charge stated that the six nurses who left the service were being replaced by four nurses.
*On Saturday and Sunday a care assistant was delegated to cover for activity provision, but the roster did not reflect that any additional resource to meet the additional demand.
*Relatives who spoke with inspectors expressed concerns about staffing levels at the weekend.

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:
• Statement of purpose has been amended to reflect the current WTE staff compliment.
• Protected office days have been allocated for the PIC and have been extended to 4 days per week. Staff compliment of nurses now ensures that this will be safe guarded.
• The four new nurses are all working full time hours as opposed to the 6 nurses who were working a mixture to full and part time hours. We now have a full complement of nurses to ensure the smooth running of the centre. Our WTE for nursing staff is now
PIC 1, CNM 1, additional nursing staff 4.74.
- On the day of inspection and prior our roster for Saturday and Sunday reflected that the activities person was part of the carers roster between the hours of 8.30- 13.00 and then activities only from 13.30-16.30 this has now been changed to a 8.00 – 14.00 person for caring duties and an activities person has been rostered from 10.30-16.30.
- The skill mix and numbers of nurses and care assistants are the same at weekends as week days, however on review of the activities co-ordinator and additional person has now been rostered from 10.30-16.30.
- No staff shall be permitted to commence employment without completed garda vetting and all mandatory training shall be up to date and ongoing. Fire training for all staff is currently underway.
- We have commenced a more robust training programme in person centred care and are carrying out observations using the QUIS tool as part of our learning programme. Results shall be audited and used as a learning tool to improve staff interactions and general standards.

**Proposed Timescale:** 19/09/2016

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff required further training to improve their skills in order to provide person centred care.

**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:**
A more robust training programme shall be put in place to ensure staff engage appropriately and provide person centred care at all times. All staff shall have access to appropriate training.

**Proposed Timescale:** 19/09/2016

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The roles and responsibilities of volunteers was not set out in writing.

**15. Action Required:**
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.
Please state the actions you have taken or are planning to take:
The roles and responsibilities of volunteers shall be set out in writing.

Proposed Timescale: 20/09/2016

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 inspectors held the view that the non compliances found on this inspection related to the failure to put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

16. 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:
We will ensure management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored this will be facilitated by PIC no working 4 office days per week and having a full staff compliments.

Proposed Timescale: 19/09/2016