Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Laurel Lodge Nursing Home
Centre ID:	OSV-0005394
Centre address:	Templemichael, Glebe, Longford.
Telephone number:	043 334 8033
Email address:	laurellodgelongford@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Templemichael Nursing Home Limited
Provider Nominee:	Rosetta Herr
Lead inspector:	Una Fitzgerald
Support inspector(s):	
Type of inspection	Announced
Number of residents on the date of inspection:	104
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
09 August 2017 09:00	09 August 2017 19:30
10 August 2017 09:00	10 August 2017 16:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of a two day, announced inspection, following an application to vary registration conditions. The centre has completed internal building renovations which will increase the capacity to a total of 114 residents.

During the course of the inspection, the inspector met with residents, relatives, staff and the management team in the centre. The views of all were listened to, staff practices were observed and documentation maintained was reviewed.

Overall, the inspector found that care was provided to a good standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The management and staff of the centre were striving to improve residents' outcomes. A person-centered approach to care was noted. Residents were well cared for, had good access to health and social care services and expressed satisfaction with the assistance and support they received in the centre. Relatives spoken to were complimentary of the care.

Management systems were in place within the centre that defines the lines of responsibility and accountability. The person in charge responsible for the

governance, operational management and administration of services and resources demonstrated sufficient knowledge and an ability to meet regulatory requirements. The person in charge is currently also fulfilling the role of Operations Director. The person in charge confirmed that this arrangement is short term only and arrangements to ensure that the overall governance and monitoring of the centre to ensure that resident care is not compromised is discussed under Outcome 2 within the body of the report.

The premises were homely, safe, suitably designed and laid out to meet the needs of the residents. The additional rooms have been added and building renovations are finished to a good standard and the design and layout of the centre is suitable for its stated purpose. This is discussed in detail within the body of the report. The person in charge also presented to the inspector the planned increase staffing compliment for the increase in resident numbers. There was good access to resources in the centre with an appropriate stock of equipment and mattresses. A new incoming person participating in management assured the inspector that the centre was well resourced in order to ensure the delivery of care as described in the statement of purpose.

The person in charge confirmed that all staff have completed Garda vetting. There are no volunteers working within the centre.

The actions required following the last inspection (22 in total) had been addressed. Of the eight outcomes inspected six were found to be compliant/substantially compliant. The findings are discussed throughout the report and areas for improvement are outlined in the action plan at the end of the report.

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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The management structure identified has clear lines of authority and accountability, and specified roles and responsibilities for all aspects of the service. Currently there is an interim arrangement in place for the person in charge to carry out the role of the person in charge and the Operations Director. As a supportive measure the management team has also nominated a new person to participate in management (PPIM) to support the person in charge. This person attends the center at a minimum every week and is involved in the oversight of the operational running of the centre. Management systems were in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. The inspector observed that the management and the retrieval of information that is under the responsibility of the operations director require review to ensure optimal communications and that issues are followed up appropriately. The inspector was not assured that the person in charge had sufficient time to ensure effective governance, operational management and administration of this centre. This was discussed with the incoming PPIM and person in charge. It was agreed that this dual role responsibility will not continue past the 18th August 2017. The management will put in additional supernumerary clinical hours to support the person in charge as an interim support measure to allow him to fulfill the requirement of two senior management roles within the centre. Staff and relatives spoken to were knowledgeable on the management team.

There were policies and procedures for the management of complaints. The complaints process was displayed in a prominent place in the reception area. The inspector reviewed the complaints log. Records indicated that complaints were minimal, a total of four to date in 2017. Residents were informed on admission of the complaints procedure. The inspector reviewed the documentation of the complaints received. A record of the outcome was documented and there was also detail if the complainant was satisfied with the outcome. Residents and relatives said that they were satisfied with the care and were aware of who they could complain to if they needed to.

The centre has an annual review of the quality and safety of care delivered to residents. Improvements are brought about as a result of the learning from the monitoring review.

Judgment:
Substantially Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
Measures were in place to protect residents from being harmed or abused. There was a policy last reviewed March 2017 which provided guidance for staff on the various types of abuse, assessment, reporting and management of allegations or incidents of abuse.

Staff confirmed and training records indicated that staff had attended training on the prevention, detection and response to abuse. Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were put in place to ensure the safety and welfare of residents.

The management team actively promote a culture that ensures residents' safety and welfare is prioritised. The inspector saw that measures had been taken to ensure that residents were protected and felt safe while at the same time had opportunities for maintaining independence. Communal areas in all units were accessible to residents. The inspector saw that there were facilities and equipment available to support residents to retain their independence. For example mobility aids, hand rails on corridors and circulating areas. The centre also has a laundry room within the dementia specific unit to support residents who choose to continue to carry out their own laundry. There was a call bell facility in all rooms that were occupied. The inspector observed throughout the two day inspection that the call bells were answered in a timely manner. This was also confirmed by the residents and families who spoke with the inspector.

Systems and arrangements were in place for safeguarding resident's finances and property. The centre currently acts as a pension agent for four residents. Documentation was reviewed and the administration personal evidenced that all monies are held in a

separate resident account.

Systems in place to promote a restraint free environment in line with the national policy was described and demonstrated. A restraint policy last updated in January 2017 was available. The centre has a record of all restraint used on each unit. Staff and records confirmed that in total 14 of the 104 residents (13%) was using bedrails that restricted movement. Of this number 9 residents had requested the use of bedrail. The inspector spoke with residents who confirmed that they felt safer with bedrails in place. The restraint policy clearly defined restraint and outlined the types of restraint, assessment, checks and review practices. The inspector reviewed files. A consent form was signed by the resident or next of kin. Care plans and evaluation records included evidence of alternatives available such as low beds and sensor alarm mats. Records of the duration of restraint and safety checks or releases were not recorded for any resident that had made the decision to continue with bedrail usage. This was discussed with the nurse management team who actioned a plan to address the gaps as a matter of priority. The inspector reviewed this documentation on the second day of inspection and was satisfied with the actions taken.

The centre has a policy on and procedures in place to support staff with working with residents who have behavioural and psychological symptoms of dementia (BPSD) also known as responsive behaviours. This policy was informed by evidence-based practice. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The inspector reviewed care plans including some for residents who had responsive behaviour. Their documentation and medicine administration records were reviewed. The care plans identified potential triggers and guided the clinical team on how best to manage any incidents. However, the documentation reviewed clearly evidenced that there were multiple instances of chemical restraint administered that was not appropriately documented in line with the policy. The guidance and system in place has templates of Antecedent, Behaviour and Consequences (ABC) assessment charts for recording any incidents. The inspector found that ABC charts were not consistently updated when incidents occurred that necessitated the use of chemical restraint. In addition there was no reference within the daily records on the rationale for the administration or the effect of the medicine. During the inspection it was observed that staff approached residents in a sensitive and appropriate manner.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The centre had policies and procedures relating to health and safety within the centre. The health and safety statement was available and was last reviewed in June 2017. The centre has a risk management policy that includes items set out in Regulation 26(1). The centre had a current risk registrar that identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents. The management team were involved in the review of incidents and accidents involving residents to identify the key cause or likely factors in order to inform control measures.

Arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. The cleaning schedule included the routine daily chores but also contained detail of a deep cleaning schedule. Household staff spoken to were knowledgeable on the system in place to ensure that the cleaning regime minimises the risk of cross infection. The standard of cleanliness throughout the building was of a good standard.

Suitable arrangements were in place in relation to promoting fire safety. The fire alarm system was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. Fire safety and response equipment was provided. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Fire evacuation procedures were prominently displayed throughout the building. Staff were trained in fire safety and those who spoke with the inspector confirmed this and were knowledgeable about fire safety and evacuation procedures. The management team informed the inspector that fire drills are carried out by an external agent but the details of the drills were not available to the inspector. The external agent did forward on this detail prior to the inspector leaving the centre. The records forwarded detailed two fire drill scenarios. A record of the drill, the scenario simulated, the numbers of persons involved, the time taken for and extent of the evacuation was detailed.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The medicine management policies had all

been reviewed between 2016 and 2017. Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the delivery and collection by the pharmacy, and checking, storage, return and disposal of medicines by nurses.

The nursing management team carry out monthly medicine management audits on each unit and the findings are reviewed by the person in charge. The centre also has an external provider that carries out an independent audit on medicine management practices. There were no reported medicine errors or near misses since the last inspection. The centre has developed a template on medicine management competencies for all registered general nurses. All members of the nursing team also complete online medicine management training on an annual basis.

The processes in place for the handling and checking of medicines received including controlled drugs were examined. Practices found and procedures described were in accordance with current professional guidelines and legislation.

Nursing staff were observed as they administered medicines. Residents were unhurried. Prescription and administration records were maintained in accordance with the centre's policy and professional standards. Of the prescriptions reviewed the maximum dose of any medicine to be administered within a 24 hour period was recorded on all as required medicines. Residents are supported to self administer medicines. The system in place minimises any risk. The documentation reviewed evidenced a risk assessment process and a detailed care plan that guides practice. The inspector spoke with a resident that currently self administers their own night time medication and the resident voiced that the staff are very supportive of this choice.

A system was in place for prescription review by the resident's general practitioner and pharmacist every three months or more frequently if indicated.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Residents' health and care needs were met through timely access to medical treatment. Residents had good access to a general practitioner and allied healthcare professionals.

The inspector focused and tracked the journey prior to and from admission of a number of resident files. The review looked at specific aspects of care such as, wound care, mobility, access to health care and supports.

The inspector saw good evidence that advice received from the multidisciplinary team was followed up in a timely manner. The detail of reviews carried out was evident within the records.

On admission all residents had a comprehensive nursing assessment. The inspector observed that initial care plans were written within the 48 hour timeframe as per the regulations. The assessment process involved the use of validated tools to assess each resident's dependency level, level of mobility; falls risk assessment and skin integrity. Assessment outcomes were linked to care plans that were seen to be reviewed at intervals of three months and more frequently when clinically indicated. Clinical observations such as blood pressure, pulse and weight were assessed on admission, and as required thereafter. Care was seen to be delivered to each resident in accordance with their identified needs. Residents spoken too were familiar with their care plan. However, the care plan review is carried out in consultation with the resident or family involvement every six months and not every four months as per the regulations.

Staff provided end of life care to residents with the support of their general practitioner and have access to specialist community palliative care services if required. Each file reviewed had an end of life care plan. This care plan is kept under regular review and was updated in consultation with the resident and where appropriate a family member. There was no resident receiving end of life care on the day of inspection. Staff outlined how religious and cultural practices were facilitated within the centre.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked. There was a system in place to ensure that special dietary requirements are communicated between the clinical team and kitchen staff. Any food allergies were clearly recorded along with resident's likes and dislikes.

Residents were assessed to identify their risk of developing pressure related skin injuries. Residents at risk had specific equipment in place to mitigate level of risk, such as repositioning regimes and pressure relieving mattresses and cushions. There was a total of five residents with wound dressing care plans in place on the day of inspection. The inspector reviewed the files of two residents with a wound. A detailed care plan was available. The inspector reviewed the wound management procedures in place. Tissue viability specialist services were available to support staff with management of any residents' wounds that were deteriorating or slow to heal.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents,

conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
The inspector followed up on the findings from the last inspection. The design and layout of the centre is in line with the statement of purpose. The premises meets the needs of all residents and the design promotes residents' dignity, independence and wellbeing. Laurel Lodge is a purpose built nursing home that can currently accommodate 107 residents. Internal renovation work and upgrading has occurred in all three units that will increase the capacity to 114 residents. The capacity within Glencar unit will increase by two residents. The Hazelwood unit will increase from 36 to 40 residents and Lissadell unit will increase from 33 to 34 residents. The furnishings and fixtures in all new rooms are finished to a high standard. Within the Lissadell unit the double room is awaiting the installation of a roof window to increase the level of natural light. The person in charge has confirmed that this work will be completed prior to the admission of any resident.

Additional work has also been carried out within the communal sitting areas within the home. There is now an additional small sitting room added to Hazelwood unit and the relocation of the nurses' station is more central. Residents and staff informed the inspector that the change has had a positive impact on the unit.

Extensive work has been completed within the dementia specific unit Glencar. There is a new cozy sitting room. The new double room is en suite and is within close proximity to a large assisted bathroom. The existing large sitting room has been redesigned and has had added partitions that allow the room to have a cozy space that accommodates small groups while still able to ensure appropriate supervision within the current staffing compliment.

The centre is homely with enough furnishings, fixtures and fittings. There is adequate private and communal accommodation. There is a sufficient supply of piped hot and cold water. Shared bedrooms are laid out to ensure appropriate screening to allow for privacy during the delivery of personal care. Handrails are provided in circulation areas and grab rails are provided in bath, shower and toilet areas. All sluice rooms have had push button locks installed as per the action plan from the last inspection. The centre has access to multiple outdoor enclosed gardens that are wheelchair accessible.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the

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

Theme:
Person-centred care and support

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

Findings:
The inspector followed up on the action plan from the previous inspection and observed that significant progress had been made to ensure that the rights, dignity and consultation of all residents is considered in the management of the centre. There was evidence of consultation with resident's and their representatives in a range of areas on a daily basis. The centre now holds monthly resident meetings and from the meetings reviewed the inspector noted good resident involvement.

The activity programme within the centre is robust and offers a wide variety of options for all residents. The inspector reviewed the findings from the last resident satisfaction survey dated February 2017 and overall the findings were very positive on the social activity programme in place and residents felt that activities were meaningful. The main reception area has a large table displaying the arts and crafts completed by residents. The centre has also started a meeting called the History Hub every four weeks. This group had a session with residents on their favourite childhood food. The chef utilized a brown bread recipe from one of the residents at the session as a snack for the following meeting.

Residents are facilitated to exercise their civil, political, religious rights and are enabled to make informed decisions about the management of their care through the provision of appropriate information. The centre had notice boards strategically placed throughout the units and communal areas to ensure that residents have easy access to information. The centre actively promoted that the centre is part of the local community and residents have access to the internet, radio, television, national and local newspapers, information and enjoyed outings to local events. There was evidence of outings that had been organized and enjoyed by residents to local festivals. The inspector was also informed of planned trips that are arranged for the coming months.

Overall there was evidence that residents have the opportunity to participate in activities that are meaningful and purposeful that suits their individual needs and interests. The documentation supporting that care plans in place to evidence individual preferences required review to ensure that they are reviewed at regular intervals.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
The actual and planned rosters for staff was reviewed. The inspector found that staffing levels and skill mix were sufficient to meet the needs of residents. The nurse management team reviewed the shift patterns to ensure there is adequate periods of rest in between shifts. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities. The person in charge explained the systems in place to supervise staff. Residents spoken to confirmed that they felt their care needs were met by staff. Recruitment and induction procedures were in place. The centre had a process for staff appraisals in place. Staff spoken with felt supported by the management team.

Evidence of current professional registration for all registered nurses was seen by the inspector. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. Training included in house mandatory training on safeguarding and safety, patient moving and handling and fire safety. The training matrix evidenced that all mandatory training was up to date.

All documents as required by Schedule 2 of the regulations for staff were maintained.

The proposed staffing whole time equivalent that is planned to meet the needs of 114 residents was discussed. The increases proposed across all departments was reviewed. The person in charge explained the proposed staffing increase. The plan is to have a minimum ratio of one staff per five residents during the morning shift. The pm will have one staff for a minimum of six residents. The nighttime staffing compliment will be a minimum of one staff member for every ten residents. The exact numbers of personnel required to ensure cover at all times will depend on existing staff requests to change working hours and requests from future employees. The person in charge informed the inspector that he feels the increase will ensure that the current level of service delivered can be sustained and that resident care will not be compromised.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Una Fitzgerald
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Laurel Lodge Nursing Home
Centre ID:	OSV-0005394
Date of inspection:	09/08/2017
Date of response:	12/09/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector observed that the management and the retrieval of information that is under the responsibility of the Operations Director require review to ensure that followed up on communication occurs. The inspector was not assured that the person in charge had sufficient time to ensure effective governance, operational management and administration of this centre. This was discussed with the incoming PPIM and person in charge. It was agreed that this dual role responsibility will not continue past the 18th August 2017. The management will put in additional supernumerary clinical hours to

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

support the person in charge as an interim support measure to allow him to fulfill the requirement of two senior management roles within the centre.

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

Please state the actions you have taken or are planning to take:
Additional Supernumerary Nursing hours have been added to the existing staffing resulting in 3 Senior Staff Nurses and an additional supernumerary Assistant Director of Nursing 0.6 WTE to support the Person in Charge as a temporary measure until the two senior management roles can be separated out to two people again as planned.

Proposed Timescale: 18/08/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The guidance and system in place has templates of Antecedent, Behaviour and Consequences (ABC) assessment charts for recording any incidents. The inspector found that ABC charts were not consistently updated when incidents occurred that necessitated the use of chemical restraint. in addition there was no reference within the daily records on the rationale for the administration or the effect of the medicine.

2. 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:
The use of chemical restraint at Laurel Lodge Nursing Home would be very infrequent and only used in situations where it is a temporary measure whilst medication can be appropriately titrated to a regular dose. Nursing staff and senior management have met to discuss the importance of recording what the behaviours which were distressing to the resident were and what effect the medication had on relieving such symptoms. The Person in Charge has reviewed this and is satisfied that the few occasions of restraint have all been appropriate. Auditing of the documentation pertaining to use of chemical restraint will take place monthly over the next four months.

Proposed Timescale: Immediate

Proposed Timescale: 12/09/2017

Outcome 11: Health and Social Care Needs
Theme: Effective care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** The care plan review is carried out in consultation with the resident or family involvement every six months and not every four months as per the regulations. **3. Action Required:** 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:** Senior management have adjusted the Case Conference planning to ensure that all resident care plans will be reviewed in conjunction with the rersident or their family at a minimum of four monthly or sooner where significant change occurs.
Proposed Timescale: 31/10/2017