Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Laurel Lodge Nursing Home
Name of provider:	Templemichael Nursing Home Limited
Address of centre:	Templemichael, Longford, Longford
Type of inspection:	Unannounced
Date of inspection:	07 December 2023
Centre ID:	OSV-0005394
Fieldwork ID:	MON-0040431

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The designated centre providers 24 hour nursing care to 114 residents, male and female, who require long term and short term care (day care, convalescence, rehabilitation and respite). The centre is a two storey building containing three distinct lodges located on the outskirts of Longford town. Glencar Lodge is a 41 bed dementia specific unit. Lissadell Lodge is a 35 bed unit and Hazelwood lodge had 38 beds. The majority of bedrooms have full en-suite facilities. The centre is decorated and furnished to a high standard and a variety of sitting rooms and seated areas, dining rooms in each lodge, a spacious oratory/chapel, a meeting room and hair salon is available for residents use. Well-manicured secure and accessible garden courtyards are available along with a number of other surrounding outdoor planted areas. The centre's philosophy is one of optimization, aimed at facilitating residents to be the best that they can be, promoting independence and autonomy by placing residents at the centre of all decision making within a 'home from home' that is safe, caring and supportive.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	111

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 December 2023	09:15hrs to 17:45hrs	Michael Dunne	Lead
Thursday 7 December 2023	09:15hrs to 17:45hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors observed that residents were supported to enjoy a satisfactory quality of life supported by a team of staff who were kind, caring and responsive to their needs. The overall feedback from residents was that they were content with the care they received and that staff looked after them very well. Residents who expressed a view told inspectors that they liked where they lived.

Upon arrival the inspectors were met by the staff who guided them through the required checks in relation to infection prevention and control measures that were necessary prior to entering the designated centre. An introductory meeting was held with the assistant director of nursing (adon), who was joined shortly later by the registered provider. Following this meeting, the inspectors commenced a tour of the building with one inspector spending the majority of their time in the dementia unit called Glencar.

Laurel Lodge Nursing Home is located in close proximity to Longford Town and can accommodate a total of 114 residents. Residents are mostly accommodated on a long term basis however there are a number of respite care beds also available in the centre. The centre comprises of three separate units called Hazelwood Lodge, Lissadell Lodge and Glencar Lodge. There were 111 residents living in the centre on the day of the inspection. All of these units provides a range of communal facilities for resident use which included unrestricted access to their own sitting and dining rooms. Communal areas leading to the accommodation units were found to be decorated and furnished to a high standard with a variety of seated areas available for residents. Other facilities made available to residents include a spacious oratory/chapel, a meeting room and a dedicated hair salon. Residents had access to a secure and accessible garden area and also to a number of courtyards which were suitable for residents to use.

Residents' bedroom accommodation in Glencar unit was arranged on the ground floor level with the majority of residents living in single bedrooms with adjoining en suite facilities. Residents had access to television and call bells in all of the bedrooms found on inspection. Residents private spaces were found to be well-maintained, clean and residents had sufficient space available for them to store and access their personal belongings. Residents' bedrooms were found to be personalised with items of personal significance such as photographs and ornaments.

Handrails were in place along all the corridors to support residents with their safe mobility. The inspector observed that residents who required assistance with mobilising were well supported by staff. There were a range of communal spaces for residents to use located in Glencar unit and included a large sitting room, a snooze room and three indoor garden/courtyard areas. A spacious dining room was also available for communal meals and was laid out with sufficient numbers of tables and

chairs available for residents to be able to enjoy their meals. Observations of a meal service confirmed that residents were offered a choice of meals and were provided with an alternative meal should they not like what was on the menu.

This unit was warm and well ventilated however many areas of the unit required decoration and upgrade due to wear and tear. These observations were also made on the previous inspection held in May 2023. The provider had an ongoing programme of decoration and upgrade and at the time of this inspection was awaiting a painter/decorator to continue painting areas of the centre.

The inspectors observed that residents living in Glencar were well-dressed and were found to be wearing well-fitting clothes and footwear. Residents were also observed being supported by staff to attend to their personal care requirements throughout the morning time. These tasks were carried out in a friendly unhurried manner. It was clear that staff were familiar with residents' care needs and that residents felt safe and secure in their presence. A number of other residents were observed to be following their own routines, while others were supported to attend the main activity room.

There were a range of activities provided during the day which included a music session held in the oratory/chapel area, and a sensory based activity in the Snooze room. Recreational coordinators led the provision of activities in the centre and worked closely with the care team to ensure that residents social care needs were met. Additional resources available in the Glencar unit included a reminiscence kitchen which featured items such as old radios and kitchen equipment found in households during the 1950s and 60s era.

The inspector found improvements in residents being able to access external communal areas, all door leading to these facilities were found to be unlocked on the day of the inspection. Glencar unit provides accommodation for residents essentially living with dementia. Some residents were found to walk with purpose and on occasion would enter other residents private bedrooms. In order to protect residents property some bedroom doors were locked to prevent this intrusion. Although, this protected the residents property it also restricted residents ability to access their own rooms independently and meant that residents had to seek the assistance of staff to enter their own room. This is further discussed under Regulation 9 Rights.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Although the provider had made significant improvements in many areas since the last inspection, the inspectors found that more focus was now required to bring the

designated centre into full compliance with the regulations. There were a number of recurring non-compliances found on this inspection in relation to fire safety, premises and infection control. Oversight arrangements regarding risk management and the systems in place to identify and monitor risk effectively were not effective in ensuring that all risks had sufficient controls in place to maintain a safe environment. This is discussed further under Regulation 23: Governance and Management and in more detail under the theme of Quality and Safety.

The inspectors followed up unsolicited information received by the office of the Chief Inspector. The concerns related to poor standards of care and a change to the charges in the contract of the provision of services. These concerns were partially substantiated on this inspection.

These charges related to costs for assistive equipment allocated as residents needs increased under an intermediate service level and under an advanced service level. For Example, if a resident required the use of two or more pieces of assistive equipment in the intermediate level range they would be charged a set fee, and should they require the use of one or more pieces of assistive equipment under the advanced level, they would be charged a higher fee.

The provider confirmed that residents are not charged for the use of assistive equipment until they sign the contract for the provision of care services and that they can opt out of this part of the contract should they decide to do so.

This was an unannounced risk inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended). During the service's previous inspection in May 2023, a number of non-compliances had been identified. The compliance plan submitted by the provider to address those findings was reviewed on this inspection to determine whether all actions had been completed within the time frames given by the provider.

Templemichael Nursing Home Limited is the registered provider of Laurel Lodge Nursing Home. A director of the company represents the provider entity. The management structure included a person in charge, an assistant director of nursing (ADON)) and three clinical nurse managers (CNMs). Health care assistants, Housekeeping, Catering, maintenance, administration and recreational staff also provided care and support to residents living in the centre.

In relation to the regulations inspected, the inspectors found that the provider had made progress in many areas including the appointment of senior clinical staff and the provision of appropriate training for staff working in the centre. The management structure within the centre had been strengthened with the appointment of an (ADON) and there were clear lines of accountability and authority in place to improve clinical oversight of residents' medical and nursing requirements. All units within the centre were now supported by a (CNM) to monitor the quality of care provision to residents and to provide regular clinical information on the residents to the person in charge.

There were significant recruitment drive since the previous inspection in May 2023

which saw the recruitment of 33 new staff to the centre and accounted for nearly 25% of total numbers of staff employed. The provider had also recruited a number of additional health care assistants to add to their pool of staff to cover vacancies on the roster. At the time of this inspection the provider was awaiting garda vetting clearance for these staff members. All nursing vacancies had been filled, while three staff nurses were within their probation period. The provider had systems in place to ensure that new staff had the required documentation place to satisfy the requirements of Schedule 2 of the Regulations.

The provider maintained an induction and probation process for all new staff recruited to the centre. The majority of staff attended a suite of training which provided them with the necessary information to develop their skills to carry out their roles effectively. Staff had completed a range of other training which included safeguarding and manual handling. There were improvements found with regard to staff attending responsive behaviour training, while a dementia specific training programme commenced in July 2023.

There were a range of oversight meetings in place to review the quality of the service provided. Monthly clinical nurse management meetings were held on each unit and were attended by the person in charge. Information reviewed included a number of key performance indicators areas of clinical care such as wound care, falls,medication,restrictive practices, falls and a review of care documentation for residents residing on each unit.

The provider attended quarterly clinical governance meetings where information collected from the quality assurance system such as audits were reviewed. These meetings provided a wider analysis of the quality of care delivered to the residents such as staff training requirements, a review of risks management, fire safety, maintenance and centre's responses to infection prevention and control.

Although quality assurance information including audits and quality improvement plans were in place however they did not identify all of the practices that posed significant risks to residents.

Systems and processes currently in place to ensure effective infection control measures were found to require improvement and were not consistent with national guidance. The risk of infection spread within the centre was increased due to the poor quality of the premises, a lack of appropriate hand hygiene sinks, ineffective auditing of key risk areas including the sluice facility and non-segregation of items stored in an equipment room.

Although the provider maintained oversight of fire safety and the suitability of the premsies, several risks were identified where current mitigation's required review, for example:

Current practices with regard to the disengaging of fire door closure mechanisms meant that the level of protection provided by these systems were reduced in spite of mitigating measures put in place by the provider.

Although the provider had a maintenance programme in place there were several

areas of Glencar unit which required upgrade such as painting and decoration.The level of wear and tear observed impacted on the quality of the lived environment for the residents. The provider failed to ensure that all items identifed in their compliance plan submitted to address findings from the inspection held in May 2023 had been implemented. Several recurring issues were identified and are described in more detail under Regulation 17: Premises.

Regulation 15: Staffing

Inspectors found that there was an adequate number of staff available with the required skill mix to provide timely support to the residents taking into account their assessed needs and the layout of the centre. Staff were observed assisting residents with their individual care needs in a timely manner.

Judgment: Compliant

Regulation 16: Training and staff development

A review of training documentation confirmed that there was a good range of training made available for staff to assist them in their respective roles such as mandatory training in fire safety, infection control, safeguarding and moving and handling. The person in charge monitored the provision of training and records confirmed there were induction processes in place to support new staff recruited to the centre.

Judgment: Compliant

Regulation 21: Records

A sample of staff files viewed by the inspector were assessed against the requirements of Schedule 2 of the regulations and were found to be complete. Garda vetting was in place for all staff and the the person in charge assured the inspectors that nobody was recruited without having satisfactory Garda vetting in place. All other records requested during the inspection were made available to the inspectors on the day or post inspection. Records were found to be maintained in an orderly and safe manner.

Judgment: Compliant

Regulation 23: Governance and management

Overall management and oversight systems maintained by the registered provider had improved since the last inspection with regard to compliance with the Health Act 2007 (Care and Welfare of resident in Designated Centres for Older People) Regulations 2013. However there were additional actions required to ensure that care and services were delivered in line with the centre's statement of purpose and that risk was appropriately managed. For example:

- Audits did not identify risks of cross contamination due to non segregation of both clinical and non-clinical items stored in the same location.
- The known risks associated with the disengaging of door closures compromised the effectiveness of the fire safety systems currently in place. Although there was a risk assessment completed for this risk and included mitigation's to reduce the risk, these were the least best options chosen by the provider and meant that an evacuation in the event of fire could be delayed and less effective as a result of staff having to ensure that room doors were secured.
- A number of additional risks identified by inspectors on the day of the inspection did not have sufficient controls in place to manage these risks. These risks are discussed in more detail under Regulation 28.
- There were several recurring non-compliance's in relation to the maintenance and upgrade of the premises. While the provider had made a number of improvements there was a significant number of upgrades that were outstanding and are discussed further under Regulation 17.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of number number of contracts for the provision of care and services. All of the contracts reviewed satisfied the requirements of the regulation. The contract between the registered provider and the resident set out the terms and conditions of the agreement and included the type of room offered to the resident upon admission. Details of additional fees for other services such as social care fees were also included in the contract.

The provider had amended the contract for the provision of services since the last inspection to include charges for the use of assistive equipment. While the details of these charges were included in appendix two of the revised contract, these details

did not give sufficient information as to when a charge was levied at the intermediate or advanced level for the use of assistive equipment. However, records made available for review on inspection confirmed, the provider communicated to residents and/or their guarantor's on a monthly basis by letter, to confirm the service level to be charged for the residents' use of assistive equipment during the previous month. The service level charged was determined following a review of residents care records.

Judgment: Compliant

Quality and safety

Residents living in this centre experienced a good standard of care and support delivered by a caring staff team. The oversight of resident's clinical needs had improved since the last inspection. A programme of clinical audit supported by quality improvement plans and regular monitoring by the provider ensured that care interventions met the assessed needs of the residents living in the centre. Despite, the implementation of improvements carried out by the provider the following Regulations were found to be recurring non-compliance's, for example: Regulation 27: Infection Control, Regulation 28: Fire Safety and Regulation 17:Premises.

Residents' needs were comprehensively assessed using validated assessment tools at regular intervals and when changes were noted to a resident's condition. There was a good standard of care planning in the centre, with a focus on person-centred care. Care interventions were specific to the individual concerned and there was evidence of family involvement when residents were unable to participate fully in the care planning process. There information reviewed in residents progress notes was comprehensive and related directly to the agreed care plan interventions.

The inspectors found that residents' health and social care needs were met through established access to health care services and a planned programme of social care interventions. The provider made a number of improvements since the last inspection to improve the oversight of clinical interventions. Information reviewed on inspection confirmed that the provider had put measures in place for effective wound care management which included training sessions delivered by a tissue viability nurse (TVN). Other measures included the requirement for new nurses to complete an online wound management course prior to commencing employment.

Information made available to the inspector indicated a reduction in residents falling in the centre. The person in charge confirmed that analysis of falls is conducted on each individual unit and results for Quarter 3 show a reduction of falls of 26% for January to September 2023. A review of falls prior to the inspection confirmed that 14 notifications for falls was received by the office of the Chief Inspector since the last inspection in May 2023. Recent audits carried out confirmed that measures to promote residents mobility were in place and monitored on a regular basis.

Residents who walked with purpose were provided with timely support and reassurance. Staff were aware of residents assessed needs and this contributed to effective interventions. In instances where responsive behaviours were observed, appropriate information was recorded in residents daily notes and in behavioural support plans. Access to specialised support such as psychiatry of old age was in place for residents who needed this level of intervention.

There were a range of activities provided for residents on the day of the inspection and are discussed in more detail under Regulation 9. Inspectors observed improvements with regard to staff interactions with residents to ensure their participation in activities. Resident records confirmed residents were consulted about the activities they would like to participate in and incorporated in their recreational care plan.

Observations of a resident meal service indicated that the provider had made a number of improvements to provide an enjoyable meal experience for the residents. The atmosphere was calm with soft music contributing to a relaxed environment. There were sufficient numbers of staff available to support residents who needed assistance with their eating and drinking.

Residents had unrestricted access to all communal areas within the Glencar unit including garden areas. However, there was a policy in place to lock some bedroom doors to prevent other residents from entering those rooms. The inspector reviewed information into this practice and found that the registered had trialled some least restrictions options prior to introducing the current measures which were found to be overly restrictive. Therefore, additional measures should be explored to maintain resident's autonomy around choice in accessing all areas of their home including their bedrooms without having to ask staff to allow entry.

The provider had made a number of improvements in relation to upgrading the premises which included the provision of new nurse call systems, the provision of new kitchen equipment, the provision new drapery and improved facilities in the dementia garden area. While there was also an upgrade regarding the provision of alcohol hand rub facilities. Despite these improvements inspector found recurring non compliance's in relation to the fabric of the building which included a number of areas which had become degraded due to wear and tear, this is discussed in more detail under Regulation 17: Premises.

There was an extensive infection prevention and control training programme available for staff in this centre. Records reviewed confirmed staff attendance at this training and those staff spoken with during the course of the inspection were knowledgeable about their role in maintaining an infection free environment. However, practices as identified under Regulation 27, compromised the deployment of effective infection control measures. In addition, the wear and tear of the fabric of the building posed challenges for the centre to be cleaned effectively.

In regards to fire safety, the inspectors observed some good fire safety systems were in place. Service records were available for the various fire safety and building services and these were all up to date. The inspectors spoke with various staff

members on duty in regard to fire safety and evacuation procedures. Staff were confident and knowledgeable with the practiced evacuation procedures.

The inspectors reviewed the fire safety register and noted that it was adequately organised and comprehensive. The in-house periodic fire safety checks were being completed and logged in the register as required. On the day of the inspection, workmen were in the centre carrying out remedial works to fire doors. The provider was making progress and was committed to bringing the centre into compliance.

A review of the providers' fire safety risk assessment dated May 2023, identified that 200 fire doors required remedial works, fire stopping works were required, and non-fire rated access hatches required replacement while fire detection was required to be fitted to an external store. All of which could lead to serious consequences for residents in a fire emergency. The findings of this inspection aligned with the findings of the provider's own fire safety risk assessment.

The provider had completed some fire stopping, compartmentation works and had fitted a new kitchen suppression system. The provider was required to submit a time-bound action plan to indicate when all the fire safety works would be completed.

The inspectors found additional fire safety risks on the day of the inspection that had not been identified by the provider. The inspector noted a number of actions were required in relation to fire precautions, emergency lighting, means of escape, emergency directional signage, evacuation, containment of fire and storage practices, to ensure compliance. These fire risks are outlined in detail under Regulation 28: Fire Precautions.

In addition to this, a high number of door closing mechanisms to bedroom fire doors had been disconnected throughout the designated centre. The inspectors were informed that residents preferred that their bedroom door was left open for their comfort or peace of mind. In addition to this, the provider had informed inspectors that individual risk assessments had been carried out for residents which included; the risk of residents being unable to enter and exit their room, especially for residents with poor mobility.

Nevertheless, in such cases, suitable hold open devices should be used along with suitable self-closers. Every effort should be made to address the needs and preferences of each resident without compromising their safety and the safety of others in the centre. This action by the provider compromised the containment measures in the centre and resulted in a significant risk for fire and smoke to spread in a fire emergency.

Overall this inspection had found that some progress had been made by the provider to address some of the fire risks in the centre identified in the fire safety risk assessment and improvements had been made since the previous inspection in regards to fire training. However, the number of fire risks that were identified on this current inspection raised concerns about fire safety management in this centre. As a result, the inspectors were not assured that there were adequate measures in place to ensure that residents living in the designated centre are safe and protected

from the risk of fire

The identified fire risks required a review by the providers' competent person and appropriate effort and resources were now required by the provider to bring the centre into compliance with Regulation 28: Fire Precautions.

Regulation 17: Premises

Some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows;

· There was inappropriate storage of three assistive chairs in the sitting room of glencar unit. The storage of resident this equipment encroached on residents communal living space.

· Inappropriate storage was found in a room containing an electrical panel and required an immediate action to reduce the risk of fire, this is discussed under Regulation 28.

· Damage to the floor of the cleaners rooms had not been repaired post installation of a new hand sink.

· The interior of the sluice room was damaged and required repair due to a number of holes found in walls.

· Damage to the linen room door required repair due to a hole in the door

· Lock required repair in the cleaning room.

· Communal walls were damaged and required repair due to the installation of a new nurse call and the relocation of cctv cameras.

Judgment: Not compliant

Regulation 18: Food and nutrition

The inspector observed that the daily menu was clearly displayed in the dining room. Residents who expressed a view were complimentary of the food provided. Residents told the inspector that there was always choice available and that they could access an alternative meal if they did not like what was on the menu.The menu which was presented in a pictorial format and confirmed a variety of different meals were prepared for the residents. The main meal on the day of the inspection included lamb stew and a chicken Maryland dish. Noise levels in the dining room were well managed, the atmosphere was calm and relaxed with soft music playing

in the background.

There were sufficient numbers of staff available in the dining room to ensure that residents were served their meals at appropriate times. Residents who required assistance with their eating and drinking were provided with discreet assistance. The inspector observed good communication technique used by staff carrying out this task where staff reassured and supported residents.

Residents had access to fresh drinking water and also refreshments and snacks at their request.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy which met the requirements of the regulations. A review of incidents and accidents was carried out by the provider in an attempt to identify learning opportunities to improve the service to the residents.

There were a number of known risks which were not well managed and had the potential to cause harm even with existing controls in place, these risks are described in more detail under Regulation 23: Governance and Management and under individual Regulations for Infection Control, Fire Safety and Premises.

Judgment: Compliant

Regulation 27: Infection control

The inspector found that there was good practices in relation to infection control at the centre, however the following areas required improvement to ensure compliance with Regulation 27 and the National Standards for Infection Prevention and Control in Community Services (2018). For Example:

- Damage to walls and holes in flooring meant that these surfaces could not be effectively cleaned.
- Access to the sink in the laundry room was hampered due storage of items in front of it.
- The labelling of assistive equipment such as hoists when cleaned required improvement as there was no record to confirm that this equipment had been cleaned in between resident use.
- The non segregation of storage in the equipment room increased the risk of cross infection in the centre.
- There was an absence of a clinical handwash sink in the sluice facility located on glencar unit.

- There were holes in the walls of the sluice room which prevented effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider failed to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- An Immediate action in regard to fire risks was issued to the provider on the day of the inspection in relation to inappropriate storage practices. This was in regard to a large mains electrical power supply, board and generator panels were present in a room that was in use as a storage area. The inspector observed flammable items such as cardboard boxes. This was brought to the attention of the person in charge who agreed to arrange for the removal of these items.
- The inspectors noted a number of door closing mechanisms to fire doors required action to ensure fire doors are never left open in a way that might facilitate the spread of a fire. For example, a fire door to an office was held wedged open by the floor finish, a fire door to a treatment room didn't have a door closing mechanism fitted and a fire door to a laundry room would not close fully when released due to a fan operating in the room.

The provider needed to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. For example, there was a lack of emergency exit signage in some internal corridors to indicate the route to access a fire exit in both directions as indicated on the providers' fire evacuation floor plans.

Some final fire exit doors used in the event of a fire evacuation were missing emergency lighting outside. For example, the inspector observed a lack of emergency lighting outside a fire exit at two protected evacuation staircases. This is required to ensure safe evacuation away from all external fire exits to the designated fire assembly points during the hours of darkness.

In the event of an emergency, this lack of signage and lighting could cause confusion and could delay an evacuation. Fire exit emergency lighting and directional signage are required to be reviewed.

On the first floor the inspectors identified a protected staircase with a landing at the top of the staircase that was very narrow and would not serve as a suitable, and

safe means of escape for the residents accommodated in that area.

The inspectors were not assured in regards to the required fire rating of some glazed vision panels that were located in rooms along some corridors. If a fire did develop in these rooms, it could potentially spread into the corridors used for evacuation purposes and compromise the residents' means of escape.

The provider needed to improve the maintenance of the means of escape and the building fabric. For example, in two separate areas the inspectors identified a large run of wooden storage cabinets located along a means of escape. The storage cabinets in one area were being used to store linen and in another area they were being used to store files, toiletries and cardboard boxes. As the cabinets were not encased in fire rated construction, if a fire did develop from these storage areas it could compromise the means of escape.

A number of fire doors required action to ensure they were being maintained to meet the criteria of a fire door. For example, a cross corridor fire door closed very fast and aggressively when tested by the inspector. Two store room fire doors had some holes that needed to be filled, A sluice room fire door had a large hole were a door handle had been modified and a fire door to a sluice room was compromised with a holes that needed attention.

In addition to this, several areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures.

While fire evacuation drills were taking place and contained good levels of detail, clarity and learning outcomes, further fire drill practice is required in order to further support staff to protect residents from the risk of fire. For example, fire drills were being carried out for the largest compartments on the first floor, which accommodated eight resident. However, a fire drill for the largest compartment located on the ground floor which accommodated 10 residents was not submitted by the provider for review. Furthermore, while progressive horizontal evacuation drills were being carried out, a review of drill reports revealed that more focus on the practice of vertical evacuation, in the event that such evacuation would be necessary.

Arrangements for containment of fire and detection in the event of a fire emergency in the centre required improvement by the provider. For example, the inspectors noted of the fire doors observed, some did not appear to meet the criteria of a fire door. Numerous doors had gaps, did not close fully when released and some were partially or completely missing fire seals. Furthermore, some doors were fitted with non-fire rated ironmongery, were damaged or missing door closers and some compartment doors had visible gaps over the permissible allowable tolerance. Doors to high risk rooms such as a kitchen and a laundry room did not reflect the fire door rating for a high risk room and required a review.

In addition to this, the inspectors observed a high number of door closing mechanisms to bedroom fire doors had been disconnected throughout the

designated centre. A fire door will only prevent the spread of fire and smoke when it is closed. Bedroom doors in designated centres should be fire resisting and fitted with self-closing devices in order to reduce the risk of the spread of fire.

These deficiencies posed a significant risk to residents in the event of a fire and would allow smoke and fire to spread easily in the event of a fire.

Compartmentation works had been carried out by the provider in the attic spaces. From a review of the providers fire safety risk assessment further fire safety works were required to ensure the spread of fire and smoke would be suitably prevented from spreading into adjoining compartments in the attic spaces. While some attic hatches had been replaced with fire rated access hatches by the provider, the inspectors noted some were still required to be replaced to ensure suitable levels of fire protection was achieved. The provider was actively working through a program of fire safety works that had been identified in the fire safety risk assessment and was committed to bringing the centre in to compliance.

The inspectors were not assured an internal store room used to house a large mains electrical power supply, board and generator panels was enclosed in the required fire rated construction. For example, the door to this room did not meet the criteria for a fire rated door and service penetrations were observed in the ceiling area that required sealing.

From a review of the providers fire safety risk assessment, an external store used for storing files and as a maintenance storage area was missing fire detection. This formed part of the scheduled fire safety works that the provider is committed to carrying out.

The inspectors were not assured all evacuation routes were suitable and safe for evacuating residents in the event of a fire emergency. For example, on the first floor the inspectors identified a protected staircase with a landing at the top of the staircase that was very narrow. An evacuation wheelchair was located in this staircase. However, due to the narrow width of the landing and the lack of space to navigate at the top of the staircase, the inspectors were not assured this was a suitable evacuation route.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care planning documentation was available for each resident in the centre. A pre-admission assessment was completed prior to admission to ensure the centre could meet the residents' needs. All care plans reviewed were personalised and updated regularly and contained detailed information specific to the individual needs of the residents. Comprehensive assessments were completed and informed the care plans. There was evidence of ongoing discussion and consultation with the families in relation to the development of resident care plans. Care plans were maintained

under regular review and updated as required.

Judgment: Compliant

Regulation 6: Health care

A review of the residents' medical notes found that recommendations from the residents' doctors and allied health care professionals were integrated into the residents' care plans. There was evidence to indicate effective management of residents' healthcare which resulted in positive clinical outcomes for residents living in the designated centre. There was an overall reduction in the number of falls recorded in the centre. The provider instigated measures to improve the management of wound care in the designated centre.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff in the centre were seen to have a good relationship with the residents, and were able to support residents with responsive behaviours effectively. Inspectors observed staff intervening with residents in a way that reduced the risk of further escalation. This was noted to support the residents to maintain a good quality of life, and reduce the need for more focused interventions.

Staff had attended a range of training courses including supporting people with dementia and managing responsive behaviours. They were seen to be implementing the learning from these courses, both in their interactions and in the records and documents setting out residents needs.

Judgment: Compliant

Regulation 9: Residents' rights

Several residents living in Glencar unit were unable to access their own room or their personal belongings without having to ask staff for assistance to unlock their bedroom door. This meant that residents were unable to have have free access to their own private space. While there was evidence in place to confirm that individual risk assessments were in place and resident or family member consent obtained prior to the residents door being locked, this measure was overly restrictive and had the potential to adversly impact on residents autonomy.

On the other hand inspectors observed that several residents' room doors were open in the Hazelwood unit and the self closure device on these doors disengaged. While some residents may prefer that their bedroom door is left open for their comfort or peace of mind. In such cases, suitable hold open devices should be used along with suitable self-closers. Every effort should be made to address the needs and preferences of each resident without compromising their safety and the safety of others in the centre.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Laurel Lodge Nursing Home OSV-0005394

Inspection ID: MON-0040431

Date of inspection: 07/12/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Audits have been enhanced to include segregation of clinical and non clinical items (completed) • A review of all available mechanisms of door closures/hold open devices will be undertaken to ascertain which option would be suitable and cost effective to ensure we reduce the risk of the spread of fire, without impacting on resident's choice, autonomy, independence or risk of falls/injury from self closers/hold open devices (review to be completed and implementation of agreed suitable mechanism to be completed by Q2 end) • The risk register will be reviewed to analyse all current risks, and to enhance the risk register to ensure risks identified on the day of inspection will be included and to ensure all risks are identified and not missed going forward (for completion by Q2 end) • In relation to the recurring non compliances in relation to maintenance and upgrade of the premises- resources had been allocated prior to the inspection in relation to this and were ongoing at the time of inspection, so had not been fully completed at the time of inspection, works continue at this time to reach compliance (for completion by Q4 end)	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A review of storage of equipment in all areas has been completed to ensure there is no inappropriate storage of equipment (completed) • Storage in the room in containing the electrical panel was removed immediately on the day (completed)	

• Sink had recently been installed, floor was identified as requiring repair and on the list of works for repair/upgrade, same due to be completed by quarter 4 end • All areas identified in the premises section relating to damage/repair to floors/walls/doors are on the list of works for repair/upgrade and are due for full completion by Q4 end using the additional resources that had been allocated prior to inspection to work on same • Lock to cleaning room door has been repaired • A full review of all doors had been completed prior to inspection by a competent person and as discussed on inspection, works are in progress to replace all doors that require same with the timebound action plan provided by the competent person (for completion by end of November 2024)

Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: • All areas identified in the premises section relating to damage/repair to floors/walls/doors are on the list of works for repair/upgrade and are due for full completion by Q3 end using the additional resources that had been allocated prior to inspection to work on same (complete) • Daily review of cleaners and laundry rooms is now being carried out by the housekeeping supervisor to ensure access to the sink is not hampered by inappropriate storage (complete and ongoing) • All staff have been provided with education relating to cleaning and decontamination of equipment and assistive devices, equipment is available for all staff to provide same, audits have been implemented to improve staff compliance with same and action where non compliance is evident (complete and ongoing) • Audits have been enhanced to include the assessment of appropriate storage and segregation and improve compliance, and action where non compliance is evident (complete and ongoing) • Replacement of sink to conform to HB10 clinical handwash sink in progress (for completion by Q2 end)	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: tems were removed on the day of inspection from the room with the electrical panel, no items will be stored in this area going forward and all staff are aware of same, same included in the enhanced audit to ensure compliance with same (completed and	

ongoing), upgrading of fire protective measures have also been commenced In this room to include fire proofing and sealing, upgrading of door to ensure the items held in this room are within a fire rated construction, same for completion by Q2 end 2024
• Door closing mechanism has been fitted to the treatment room (completed)
• Door closing mechanism to laundry door has been altered to allow full closure of the laundry door (completed)
• Fire door to office that was wedged open by the floor finish requires replaced (completed)
• Review of emergency lighting (to include external lighting at emergency exits) and signage has been undertaken and additional emergency lighting and signage sourced and for fitting as per the fire evacuation floor plans (for completion by end of Q2)
• Glazed vision panels on Lissadell sitting room will be replaced to fire rated panels by end of Q2 2024
• Wooden cabinets to be upgraded to a fire rated construction (for completion by Q3 end)
• The hold open device on the cross corridor fire door has been adjusted to slow down its closure to a safer speed (completed)
• Following review of fire doors by a competent person, the provider was provided with a time bound action plan for replacement/upgrading of all required doors and the provider is currently working through this and remains within the time specified for completion, this includes all fire doors referenced in this report, including doors that require higher risk rating doors (for completion by end of November 2024)
• The provider had contracted an external company to complete all fire sealing within the building, this company has been contacted to review again their fire sealing measures, highlighting the areas that had not been completed during the fire sealing process. The company will undertake remaining fire sealing and same is due (for completion by end of November 2024)
• Vertical evacuation has been added to the fire drill schedule as a pre drill objective to include more of same in the monthly fire drills (completed and ongoing)
• A review of all available mechanisms of door closures/hold open devices will be undertaken to ascertain what the best option would be to reduce risk of the spread of fire without impacting on resident's choice, autonomy, independence or risk of falls/injury from self closers/hold open devices (for completion and implementation by q2 end)
• fire detection system for the external building for maintenance and file storage has been installed (completed)
• Although the staircase is narrow on the first floor, same as been tested and trialled for evacuation including the use of a ski sheet and the space allows safe and suitable evacuation

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Locking of bedroom doors when residents are not in their rooms on Glencar has been ceased

• A review of all available mechanisms of door closures/hold open devices will be reviewed to ascertain what the best option would be to reduce risk of the spread of fire without impacting on resident's choice, autonomy, independence or risk of falls/injury from self closers/hold open devices (review completion and implementation end of Q2 2024)

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/12/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	31/12/2024

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/06/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/06/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/11/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are	Substantially Compliant	Yellow	23/02/2024

	aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	23/02/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	23/02/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/09/2024