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 Glebe, Longford, Longford
Type of inspection:	Announced
Date of inspection:	08 August 2024
Centre ID:	OSV-0005394
Fieldwork ID:	MON-0042997

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 8 August 2024	09:00hrs to 18:00hrs	Michael Dunne	Lead
Thursday 8 August 2024	09:00hrs to 18:00hrs	Ann Wallace	Support

What residents told us and what inspectors observed

Residents living in this centre were supported to enjoy a good quality of life. The inspectors found that the residents were content living in the designated centre and comfortable in the company of staff, who were observed to be attentive to residents' needs for assistance and support. Staff interactions with residents were observed to be caring, gentle and respectful throughout the day of this inspection. The inspector's reviewed feedback from resident questionnaire's on the quality of the service provided and found that all responses were positive, with residents indicating that this was a great place to live.

Shortly after arrival at the designated centre, and following an introductory meeting with the person in charge and the assistant director of nursing (adon), the inspectors completed a tour of the designated centre with the provider, where they had the opportunity to meet with residents and staff.

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; Hazelwood Lodge, Lissadell Lodge and Glencar Lodge. Glencar Lodge provides care and support for residents living with Dementia. There were 111 residents living in the centre on the day of the inspection. All of the three units provided a range of communal facilities for resident use which included unrestricted access to their own sitting and dining rooms. Other facilities made available to residents included a spacious oratory/chapel, a meeting room and a dedicated hair salon. Residents had access to secure and accessible garden areas, and also to a number of courtyards which were suitable for residents to use.

During the tour of the centre, the inspectors noted that there was good use of notice boards to update residents on the availability of activities, access to advocacy and on how to register a complaint. There was signage available in the centre to direct residents to key locations such as sitting rooms, dining rooms and to the nurses station. Residents had unrestricted access to a number of garden and courtyard areas which were well-maintained by the provider. These facilities were adorned with plants, shrubs and well-maintained pathways that residents could safely use. A number of resident rooms looked out onto the courtyard area of Hazlewood Lodge and the garden area of Lissadell Lodge, and there was potential that residents or visitors passing these windows would be able to see into the bedrooms. This was pointed out to the person in charge during the inspection.

Residents' bedroom accommodation was arranged across the ground and first floors in both single and twin occupancy rooms, some with adjoining en-suite facilities. Residents had access to television and call bells in all of the bedrooms. Residents private spaces were found to be clean and well-maintained. Residents’ bedrooms

were also found to be personalised with items of personal significance, such as photographs and ornaments.

Residents had sufficient space available for them to store and access their personal belongings, including a lockable safe for residents to store personal items securely, although the layout of two bedrooms located on Glencar unit did not ensure that both residents could have a bedside locker and a comfortable chair beside their bed.

However, one bedroom on Lissadell Lodge unit did not ensure the privacy and dignity of the residents, as the position of one of the privacy curtain rails meant that one resident would have to enter the bed space of the second resident accommodated in the room to access their en-suite facility. The provider was made aware of this and was in the process of ordering a replacement curtain rail before the inspection concluded. In addition, the inspectors were not assured that one twin room located on Lissadell Lodge unit was suitable for two residents sharing this space. Although, this room met the size requirements of the regulations, the first bed was set into an alcove behind the entrance door which meant that the resident accommodated in this bed could not see either the window or the rest of the bedroom. As a result there was insufficient natural light illuminating this bed space. Although the provider had installed a sky light, and decorated this space in bright colours, this space felt confined and did not afford the resident a pleasant private space when they were in bed or sitting beside their bed.

There was evidence to show that residents were offered choice in key aspects of their care. This included discussions on what activities residents would like to engage in, the choice of food they would like to eat, and on how residents would like care support to be provided to them. There were robust communication systems in place to ensure that residents were kept informed regarding key events in the centre with resident meetings held on a regular basis.

Resident were supported in all of the units visited, to engage in the activities provided. Inspectors observed residents participating in numerous activities throughout the day, which included pet therapy, baking, an exercise activity, music and religious services. Some residents preferred to remain in their rooms for periods of the day, and inspectors observed staff attending these residents and providing one to one support where needed. There were sufficient staff to support those residents who had additional needs. For example, the inspectors observed an interactive memory-focused stimulation session involving four residents on Glencar unit. The residents were living with dementia and had significant cognitive impairment, however, they were participating fully in the session and it was clear that they were enjoying the activity.

The inspectors observed that residents were well-dressed and were found to be wearing well-fitting clothes and footwear. Residents were observed being supported by staff to attend to their personal care requirements. These tasks were carried out in a friendly, unhurried manner. It was obvious that staff were aware of residents' needs, and that residents felt safe and secure in their presence.

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

This was a well-managed centre which ensured that residents were provided with good standards of care to meet their assessed needs. For the most part, there were effective management systems in place, which provided oversight to maintain these standards. The management team were proactive in response to issues identified through audits with a focus on continual improvement. The provider and person in charge had introduced a number of improvements since the previous inspection, and this was reflected in the improvements in compliance that were found on this inspection. However, some of the actions the provider had committed to take to bring the centre into compliance with Regulation 28: Fire Precautions, remained outstanding but were scheduled to be completed in the coming weeks.

This was an announced 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). In addition, inspectors also followed up on the compliance plan the provider agreed to implement following an unannounced inspection carried out in December 2023. Inspectors found that the provider was working towards implementing their compliance plan in respect of addressing non-compliance identified on the previous inspection with regard to infection control, premises, and fire safety.

Inspectors also followed up on unsolicited information received by the Chief Inspector in 2024, including information received in the days prior to this inspection. This information related to concerns about medicines management, admissions of residents and staff management. A review of records and discussions with staff and management did not find evidence to substantiate these concerns.

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.

The registered provider maintained systems to ensure that the service was effectively monitored. There was a programme of audits in place to review clinical care and social care provided to the residents. Overall, audits were found to have associated action plans in place to mitigate against risk and to improve the service provided. However, the auditing system had failed to identify a number of fire safety and infection control risks and therefore, there was no mitigation's in place to

manage these risks. This is discussed in more detail under Regulation 23: Governance and Management.

Management meetings were held on a regular basis to review the service and to identify areas that required improvement.. The provider was using resident feedback and resident satisfaction questionnaires to develop service provision.

The management structure within the centre had been maintained by the provider since the last inspection in December 2023, and there were clear lines of accountability and authority in place to improve clinical oversight of residents' medical and nursing requirements. Currently, there were no staff vacancies in the designated centre, however, the provider had plans in place to recruit for a number of health care assistant roles that were to become vacant later in the year. Inspectors visited all three units in the centre and found that there were sufficient numbers of staff available to meet the assessed needs of the residents living there.

A review of Schedule 2 records confirmed that staff recruited by the provider met the requirements of the regulations. Records reviewed as part of the inspection found that staff had a Garda Siochana vetting disclosure in place prior to commencing work in the designated centre. Additional information maintained by the provider included staff employment histories, records of qualifications, references from previous employers and staff identification documentation. Inspectors noted that there were well-maintained records to support staff during their induction and probation period of employment.

There were effective supports in place for staff to attend regular training to enable them to perform their duties to a high standard and ensure positive outcomes for the residents. Staff discussed their training programme with inspectors and described how training informed their day-to-day work practice. Clinical staff were seen to attend a range of training to maintain their professional competence. For example, training was in place to support medication management, wound care, falls prevention, and urinary tract infection training.

A review of the complaints records confirmed that the provider was managing complaints in line with the updated complaints policy. There was effective oversight of complaints with corrective action taken to resolve issues that impacted on the quality of the service.

A review of records relating to incidents and accidents confirmed that there was effective oversight in place to ensure that all incidents were thoroughly investigated. The provider was eager to learn from incidents in order to identify trends and improve the quality of services provided in the centre. Records confirmed that all incidents that required a notification were submitted to the Chief Inspector.

Regulation 15: Staffing

On the day of the inspection, there was a sufficient number with appropriate knowledge and skills to meet the assessed needs of residents, in line with the provider's Statement of Purpose.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a comprehensive training programme, which included induction training and ongoing mandatory training. A review of the centre's training matrix indicated that staff had received training in line with the designated centres training policy. As a result, staff were clear about what was expected of them in their work and demonstrated safe practices.

Judgment: Compliant

Regulation 21: Records

Records, in accordance with Schedule 2, 3, and 4, were made available for inspectors to review. A sample of staff records confirmed that all documentation, which included a full and comprehensive employment history, employment references and Garda Siochana vetting, were maintained by the provider.

This ensured that appropriate staff were recruited to the centre's workforce.

Judgment: Compliant

Regulation 22: Insurance

The provider had a contract of insurance in place against injury to residents which had been renewed in May 2024.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the registered provider had management systems in place to monitor the quality of the service provided however not all of these systems were

effective to ensure that potential or actual risks were identified promptly and managed effectively. For example:

- The monitoring of fire safety was not sufficiently robust to ensure that all risks related to fire safety were identified and mitigated. This is discussed in more detail under Regulation 28: Fire precautions.
- In addition, the effectiveness of infection prevention and control strategies was diminished due to ineffective monitoring. The system of audit was not identifying a number of infection risks found on this inspection and as such action plans to address these risks were not developed.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed several contracts for the provision of care and services. All of the contracts reviewed met the requirements of the regulations. 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 were also included in the contract.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place which set out the services that were offered by the centre and was found to have been updated in May 2024.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge ensured that all relevant adverse incidents were notified to the Chief Inspector in the recommended format and within the specified time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy in place which had been updated in line with regulatory requirements. Records of complaints were maintained in the centre, and the inspectors observed that these were acknowledged and investigated promptly and the complainant's satisfaction was documented.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider ensured that policies and procedures were in place, reviewed and updated where necessary. All polices had been reviewed within the previous three years with the last update recorded in December 2023. Policies and procedures were made available to the staff team to provide guidance and support in their daily work.

At the time of this inspection the provider was reviewing policies in relation to the temporary absence and discharge of residents, and in the management of responsive behaviours in response to two issues that had recently occurred in the centre.

Judgment: Compliant

Quality and safety

The inspectors found that the provider had made significant improvements to the quality and safety of care for residents since the last inspection in December 2023 and, as a result, residents were enjoying a good quality of life, in which their preferences and self care abilities were promoted.

Significant improvements had been made to the lived environment in the centre, especially for those residents accommodated on Glencar Lodge. This included the installation of a post office corner and a cafe corner. These were identifiable by large bright murals on the walls and comfortable seating. These were newly installed and were not observed to be used by residents on the day, however, staff had plans in place to encourage residents to use these areas for activities and relaxation, in addition to the main lounge, which became crowded at times. The sensory room on Glencar Lodge had also been reviewed since the last inspection and now provided a pleasant quiet environment for residents to participate in sensory sessions and other dementia appropriate sensory activities. The provider had also made some changes to the dining room to reduce noise levels and improve

the dining experience for residents. Overall, the atmosphere was much improved on this unit and was noted to be calm and supportive for the residents. It was evident that staff knew the residents well and were familiar with their needs and their preferences in how they spent their day. Visitors were observed coming and going on the unit throughout the day and were made welcome.

Residents on all units made good use of their communal spaces throughout the day. Both lounges on Lissadell Lodge provided comfortable seating for residents. In addition, there was a dining room on each floor of the unit and residents could choose to take their meals in the dining room or in their bedroom. Residents who did not take part in activities were observed chatting together or with staff.

Hazelwood Lodge unit had a large communal lounge overlooking the main entrance to the designated centre. There was comfortable seating for residents and seating was arranged into sections to facilitate residents to socialise together or to take part in small group activities. Residents had access to a separate dining room which was well used on the day of the inspection.

Residents told the inspectors that they enjoyed their meals and that there was plenty of choice on the menus. This was validated by the inspectors observations on the day. There were sufficient staff available at meal times to support residents with their nutritional needs and residents were supported to eat independently. For those residents who needed additional support at meal times, staff offered discreet assistance in a respectful manner. Music was playing in Glencar Lodge dining room which helped to reduce the noise of crockery and cutlery that had been observed on previous inspections. Residents ate well and appeared to enjoy their lunch.

Although inspectors found that the provider had implemented some improvements in relation to infection prevention and control processes, full compliance was not observed, as set out under Regulation 27: Infection control.

The provision of activities had also improved on each unit since the last inspection, and inspectors observed different activities happening on each unit throughout the day. Activities were organised by the activities team with the help of care staff working on each unit. Residents, or their family members, had completed a life history which included their preferences for social interactions and meaningful activities. Staff who spoke with the inspectors were knowledgeable about individual resident's preferences for daily routines and meaningful activities and how best to support them with this aspect of their day.

Following the previous inspection in December 2023, the provider had commenced a significant programme of fire safety improvement works based on a Fire Safety Risk Assessment that they had been carried out in 2023. As a result, the inspectors found that compliance with Regulation 28: Fire precautions had improved however, the findings of this inspection was that fire safety management was not fully in line with the requirements of regulations.

Overall, residents' rights were promoted in this designated centre. Findings on the day showed that residents were able to make decisions about their care and daily routines. Resident meetings were held regularly and residents' views were actively

sought through questionnaires and other feedback. Information in relation to complaints, advocacy and health promotion opportunities was provided to support residents to make informed choices.

Regulation 11: Visits

There were appropriate arrangements in place to ensure residents could meet with their visitors as they wished. Visitors were observed coming and going throughout the day and told the inspectors that they could visit at times to suit them and the resident. There was a visitors book to sign which ensured that staff were aware of who was in the building, and which of the three lodges they were visiting.

Visitors were seen meeting with residents in private areas located around the entrance lounge, as well as with the residents in their bedrooms.

Judgment: Compliant

Regulation 17: Premises

Overall the inspectors found that significant improvements had been made to the lived environment since the previous inspection in December 2023. The provider had completed a significant refurbishment and redecorating programme which had improved the lived environment for residents especially those residents accommodated in Glencar Lodge. However further actions were required to ensure the premises met the needs of all residents and that the requirements of Schedule 6 were met in full. For example;

- Tables and chairs located on the terrace outside residents' bedrooms on Hazlewood Lodge were visibly dirty and needed cleaning.
- Inspectors observed some stains on areas of the carpet on one corridor in Lissadell Lodge.
- Although the provider had made a number of changes to the layout of a twin bedroom 21 located on the first floor of Lissadell Lodge these changes had not addressed the low light and confined environment in the first bed space in the room. As a result this bed did not meet a resident's need for adequate light and felt quite claustrophobic as the resident could not see either into the rest of the bedroom or out of the door to the corridor when they were in bed or sat beside their bed.
- The layout of twin bedroom 3 on Glencar Lodge did not ensure that both residents could have a bedside locker and a comfortable chair beside their bed.

- The layout of single bedroom 6 on Glencar Lodge did not ensure that the resident was able to access their overbed light as it was too far away form the bedhead.
- One of the communal bathrooms on Glencar Lodge was in need of significant refurbishment as it did not meet the assessed needs of residents. The base of the shower located within this facility was damaged and a number of wall tiles were cracked and needed to be replaced. The bathroom floor, was not a safe non slip surface and therefore created the risk of slips and falls.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a resident's guide which provided information about the services and facilities that were available in the designated centre. The guide included information about the complaints procedure, advocacy and the arrangements for visiting.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy which met the requirements of the regulations. Overall known risks were well-managed in this centre, in instances where hazards were identified, appropriate controls were put in place to either remove or reduce the identified risk. 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. However, there were some risks which had not been identified by the provider and as such did not have mitigation in place, these risks are discussed in more detail under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 27: Infection control

This inspection found that procedures were not fully consistent with the national standards for the prevention and control of health care associated infections. For example;

- There was no hand hygiene sink in the laundry facility on Lissadell Lodge.

- The hand wash sink in the laundry off Glencar Lodge was blocked by laundry baskets and other items and was not being used by staff.
- A cupboard in the laundry on Hazlewood Lodge was damaged and could not be cleaned effectively
- A linen cupboard on Hazlewood Lodge was not secured which posed a risk of transmission of infection.
- The hand wash sink in the janatorial room on Glencar Lodge was small and shallow which made it liable to splash back when in use.
- A non slip bath mat was draped over a hand rail in a communal bathroom. There was not system in place to show that this mat had been cleaned between resident's use.
- Surfaces in a communal bathroom on Glencar Lodge were damaged in a number of places and could not be cleaned effectively.
- Some tables and chairs located on the terrace outside some residents' bedrooms on Hazlewood Lodge were visibly dirty and needed cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the significant fire safety improvements works that had been completed in the designated centre some further actions were required to ensure full compliance with Regulation 28 and ensure all residents were adequately protected form fire. For example;

- The oversight of fire door checks had not identified that a number of fire doors on Glencar Lodge were not closing correctly even after the improvement works had been completed on these doors.
- A number of door closures on bedroom doors in Glencar Lodge were not in place which meant the room doors did not automatically close when the fire alarm sounded. The delay in fitting these closures was as a result of supplier delays. Inspectors were assured that the risk was identified and staff knew to manually close these doors if the alarm sounded. However there was no record of this in recent fire drill records.
- The ceiling hatch in the laundry on Lissadell Lodge was not fire rated. This was significant as the laundry is a high risk area. the provider committed to replacing the ceiling hatch as a priority.
- A slide bolt was fitted to the outside of two bathroom doors. This created a risk of a resident or staff member being locked in the bathrooms from the outside.
- One member of staff who spoke with the inspectors was not able to clearly articulate the procedure to take when the fire alarm sounded. This was confirmed in the records of a fire drill completed in July 2024 where a member of staff had not followed the correct procedure.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Residents had access to pharmacy services of their choice.

Medication records were up-to-date and stored securely. Nursing staff were aware of individual residents' medication needs. The inspectors found that prescribed medications were administered safely in line with An Bord Altrainas agus Cnaimhsechais guidance for the safe administration of medications and that residents received medications in line with their General Practitioner's instructions for administration.

There were clear systems in place for the safe storage of medications and the ordering and disposal of medications that were no longer in use.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Each resident had an assessment of their needs completed prior to and on admission to the designated centre. This helped to ensure that that the centre could meet the resident's needs.

Following a comprehensive admission assessment, nursing staff developed a care plan with the resident and their family or representative. The care plans reviewed on inspection were person-centred and reflected the resident's current needs. As a result, the care plans provided the information that nursing and care staff required to provide safe and appropriate care for each resident.

There was clear evidence that care plans were regularly reviewed and that residents, or where appropriate, their representative were involved in those reviews.

Judgment: Compliant

Regulation 6: Health care

Residents had good access to their General Practitioner(GP) and specialist medical services. Records showed that residents saw their GP regularly, and where specialist medical input was required, referrals were made in a timely manner.

Residents had access to the wider health and social care team including physiotherapy, occupational therapy, tissue viability nurse, speech and language therapy and the dietitian. Referrals were made in a timely manner. Care pathways were in place for referrals such as physiotherapy following falls. This helped to ensure that residents were seen by specialist services promptly. Where specialist practitioners made recommendations to the resident's care plan, these were implemented by staff.

Residents also had access to a range of health promotion and screening opportunities, in line with the national screening programmes.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The provider had recently reviewed the policies relating to residents who displayed responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). This review was carried out following a significant incident that had recently occurred in the centre. The review included staff training, transfer documents and communications with acute service providers and the provider's responsive behaviours and admissions policies.

Staff had access to training in the management of responsive behaviours. This helped to develop their skills and knowledge to respond to and manage these behaviours and support residents.

Staff demonstrated appropriate knowledge and skills in their work and were observed using appropriate verbal and non-verbal actions to reassure residents who were becoming anxious or who were displaying responsive behaviours. These actions were empathetic and person-centred and supported the resident effectively.

There was evidence that the provider was working towards a restraint-free environment. Restrictions, such as door locks, had been reviewed following the last inspection. The number of bed rails had also been reduced since the last inspection. Equipment, such as alarm mats, had increased, however, records showed that these were being used in line with the national guidance on the use of restraints, and were being monitored on the designated centre's restraints register.

Judgment: Compliant

Regulation 8: Protection

The registered provider had taken measures to protect residents from abuse. There was an up-to-date safeguarding policy in place which was well-known among the staff team. Staff demonstrated a good awareness in relation to their role in keeping residents safe, and were aware of when to report a concern. The provider acted as a designated pension agent for nine residents. A review of records found that there was a robust and transparent process in place to ensure that residents finances were safeguarded. Residents were provided with statements of account, when requested.

Judgment: Compliant

Regulation 9: Residents' rights

Eight resident bedrooms overlooked the secure courtyard on Hazelwood unit. Residents and visitors passing by these windows whilst using the courtyard could see into these bedrooms when the curtains were not closed. As a result there was potential for residents privacy and dignity to be impacted should they wish to carryout out personal activities at these times.

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 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Laurel Lodge Nursing Home OSV-0005394

Inspection ID: MON-0042997

Date of inspection: 08/08/2024

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Slide bolts were removed on the day of inspection • An audit was carried out on all doors in the nursing home to confirm no further slide bolts exist on the outside of doors • Ceiling hatch has been replaced and is now fire rated • All ceiling hatches have been reviewed to ensure all ceiling hatches are fire rated • Regular "walkabout audits" are carried out by the person in charge and maintenance manager to ensure any fire rated constructions have not been compromised • All automatic closers have now been installed on doors that were missing them while we were awaiting their delivery • Weekly checks of cross corridor fire doors and monthly checks of bedroom door/other room doors has now been implemented to ensure doors are closing correctly • Monthly fire audits are completed with staff and monthly fire drills are completed to ensure staff are aware of fire procedures and have knowledge of fire safety and prevention and what to do when a fire alarm alerts/they discover a fire, where there may be a language barrier, which was the case in relation to this one staff member, we have translated the fire audit to their language to ascertain their knowledge and understanding of the training, and have a staff member who can speak their language translate the information from the trainer to ensure they fully understand what is being said, and then their knowledge is re-audited on a regular basis and they are observed during fire drills to ensure they follow correct procedure • A handwash sink has been installed in Lissadell laundry • A daily "walkabout" by the DON/ADON is completed in all areas such as clinical rooms/laundry rooms/sluice rooms etc to ensure sinks are not being blocked, and same discussed at departmental meetings • The cupboard in the laundry room in Hazelwood has been reupholstered and all facilities in all laundries have been reviewed to ensure all surfaces allow for effective cleaning • The linen cupboard on hazelwood has a lock installed now, all other linen cupboards	

checked also and all have locks
• Handwash sink is in the process of being replaced and will be completed by end of October 2024
• Non slip mat is no longer in use as bathroom has been refurbished and no longer required
• Three communal bathrooms have been refurbished in Glencar, with works completed
• Tables and chairs outside have been added to the cleaning schedules
• All areas of risk identified during inspection that had not been identified prior have been added to relevant audits/controls for risks

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Tables and chairs outside have been added to the cleaning schedules
• Plans in development to refurbish flooring in Lissadell, with plans for completion by February 2025
• Room 3 has been re-arranged to ensure residents have a bedside locker and chair within their bedspace
• Overhead lights have been reviewed in all areas to ensure all residents have access within their bedspace to turn them on
• Three communal bathrooms have been refurbished on Glencar, works now completed
• Room 21 Lissadell will undergo a complete re-configuration and refurbishment which will include moving (swapping) the location of the existing bathroom across to the area currently by the bed in the area with the roof light creating additional bed space in the room for the second bed to be located where the bathroom is currently located ensuring both occupants have access to natural light as well as open space, with plans for completion by March 2025

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• A handwash sink has been installed in Lissadell laundry
• A daily "walkabout" by the DON/ADON is completed in all areas such as clinical rooms/laundry rooms/sluice rooms etc to ensure sinks are not being blocked, and same discussed at departmental meetings
• The cupboard in the laundry room in Hazelwood has been reupholstered and all facilities in all laundries have been reviewed to ensure all surfaces allow for effective cleaning

• The linen cupboard on hazelwood has a lock installed now, all other linen cupboards checked also and all have locks
• Handwash sink is in the process of being replaced and will be completed by end of October 2024
• Non slip mat is no longer in use as bathroom has been refurbished and no longer required
• Three communal bathrooms have been refurbished in Glencar, with works completed
• Tables and chairs outside have been added to the cleaning schedules

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Slide bolts were removed on the day of inspection
• An audit was carried out on all doors in the nursing home to confirm no further slide bolts exist on the outside of doors
• Ceiling hatch has been replaced and is now fire rated
• All ceiling hatches have been reviewed to ensure all ceiling hatches are fire rated
• Regular "walkabout audits" are carried out by the person in charge and maintenance manager to ensure any fire rated constructions have not been compromised
• All automatic closers have now been installed on doors that were missing them while we were awaiting their delivery
• Weekly checks of cross corridor fire doors and monthly checks of bedroom door/other room doors has now been implemented to ensure doors are closing correctly
• Monthly fire audits are completed with staff and monthly fire drills are completed to ensure staff are aware of fire procedures and have knowledge of fire safety and prevention and what to do when a fire alarm alerts/they discover a fire, where there may be a language barrier, which was the case in relation to this one staff member, we have translated the fire audit to their language to ascertain their knowledge and understanding of the training, and have a staff member who can speak their language translate the information from the trainer to ensure they fully understand what is being said, and then their knowledge is re-audited on a regular basis and they are observed during fire drills to ensure they follow correct procedure

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Privacy tints for windows will be sourced and trialed to ensure they do not have an overly negative impact on the natural light entering the room, We intend liaising with other operators who have fitted same by way of referencing their actual experience to

ensure best outcome is achieved. We would expect same should be chosen and installed in required rooms by end Q1 2025

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.	Substantially Compliant	Yellow	01/03/2025
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.	Substantially Compliant	Yellow	31/10/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	31/10/2024

	associated infections published by the Authority are implemented by staff.			
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.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals,	Substantially Compliant	Yellow	30/09/2024

	that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are 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.	Substantially Compliant	Yellow	30/09/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/01/2025