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:	Lystoll Lodge Nursing Home
Name of provider:	Lystoll Lodge Nursing Home
Address of centre:	Skehenerin, Listowel, Kerry
Type of inspection:	Unannounced
Date of inspection:	02 October 2019
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0027363

About the designated centre

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

Lystoll Lodge Nursing Home is situated in the countryside in peaceful surroundings approx one mile outside the heritage town of Listowel. The Nursing Home is serviced by nearby restaurants/ public houses/ libraries/ heritage centre and various shops. 24-hour nursing care is available which is led by the person in charge, who is a qualified nurse. Staff participate in regular training courses to maintain and improve the level of care for residents. Lystoll Lodge Nursing Home employs 50 staff. All staff and visiting therapists have the required Garda Vetted (GV) clearance in place. Accommodation is available for both male and female residents requiring continuing care, respite care, convalescence care, dementia care, psychiatric care and end-of-life care. Admissions to Lystoll Lodge Nursing Home are arranged by appointment following a pre-admission assessment of needs. This is to ensure that the centre has all the necessary equipment, knowledge and competency to meet residents' needs. On admission all social activities/hobbies, leisure interests and local amenities available to residents, are discussed. For example, local social events such as Listowel races and Listowel writers' week can be accessed. A care plan will be developed with the resident's participation within 48 hours of admission. This will be individualised for personal care needs and will provide direction to staff members. All food is prepared freshly and cooked by the chefs who tailor meals to meet the preferences and requirements of residents.
Residents meet on a quarterly basis to discuss any improvement or changes that they would like to see in the operation of the centre. An open visiting policy operates within Lystoll Lodge Nursing Home. Complaints will be addressed and the complaints policy is set out in the statement of purpose.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

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
02 October 2019	10:45hrs to 19:00hrs	Mary O'Mahony	Lead
03 October 2019	09:00hrs to 17:45hrs	Mary O'Mahony	Lead
02 October 2019	10:45hrs to 19:00hrs	John Greaney	Support
03 October 2019	09:00hrs to 17:45hrs	Niall Whelton	Support
03 October 2019	09:00hrs to 17:45hrs	John Greaney	Support

What residents told us and what inspectors observed

Residents and relatives spoken with by inspectors expressed that they were content in the centre and that staff were kind to them.

Mealtimes were very social events and the choice and quality of food was widely praised.

Residents were generally happy with the range of activities and stated that they enjoyed the outings and the card games.

Residents' meetings afforded an opportunity to express concerns or discuss their experiences. The minutes of these meetings were seen to be recorded and were available to inspectors.

Inspectors found that a number of residents had said that they felt 'rushed' at times. Nevertheless, these occurrences were recorded and addressed when they had been brought to the notice of management personnel.

Inspectors were told that visitors were always welcome and they were seen to sit with residents and converse about social and family events.

Residents were familiar with the new management team and members of the staff group. They expressed confidence to inspectors that they felt safe in the centre.

Capacity and capability

This unannounced inspection of Lystoll Lodge Nursing Home took place in light of concerns from the office of the Chief Inspector in relation to the negative impact on the lives of residents resulting from inadequate governance and management systems, as found on previous inspections. The centre had established a record of repeat non-compliance with Regulations and inadequate provider responses to actions from the four inspections completed since 7 November 2018: namely the inspections of 07/11/18, 04/02/19, 03/04/19 and 8 and 9 May 2019. The registered provider had failed to establish and maintain systems to demonstrate a capability to monitor, identify poor practice and respond to poor performance. As a consequence the Chief Inspector had issued a notice of proposed decision to cancel the registration renewal of Lystoll Lodge Nursing Home. In accordance with Section 54 of the Health Act 2007 the provider had subsequently made written representation to the Chief inspector which included a submission and action plan which

specified the proposed improvements. This inspection was scheduled to evaluate the impact of these improvements and the impact of the new governance and management structure on the two dimensions of care inspected against in this report, namely: Capacity and Capability and Quality and Safety of Care.

While inspectors found that there were still a number of significant non compliances in relation to Regulations under these dimensions, the findings from this unannounced inspection of 2 and 3 October 2019 demonstrated that that the provider had instigated a number of improvement initiatives in the centre. These improvements were acknowledged by inspectors albeit they were at an early stage due to the challenges of establishing a new management team. The new team were found to be aware of the need for robust systems to be put in place to support and supervise staff, to manage complaints, to monitor and identify poor practice and demonstrate that performance improvement plans were in place, where appropriate.

Prior to the appointment of the new person in charge external advisers had been working with the management staff. They had supported the induction of the new registered provider representative (RPR). They had also developed audit and training, initiated document review and advised on investigation processes during their time in the centre. The aim of these interventions was to support the new team to achieve regulatory compliance and to be made aware of best practice protocols.

The newly appointed registered provider representative and the new person in charge were found to be suitably qualified and experienced in older adult nursing and social care management. At the feedback meeting following this inspection the registered provider representative was requested to provide an updated action plan in relation to progressing the previous plan which had been submitted following the notice of proposal to cancel registration of the centre.

Some improvements were noted by inspectors in relation to Governance and management arrangements. These are detailed under Regulation 23 in this report.

A number of the records and documentation as required by Schedule 2, 3 and 4 of the Regulations were available in the centre. Nevertheless, not all records were available, securely stored, well maintained or accessible to inspectors. The regulatory required documents which were not available to inspectors were outlined in more detail under Regulation 21 in this report.

This finding was of particular concern to inspectors as this was a repeated non compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres For Older People) Regulations 2013 (as amended).

In summary, despite a number of improvements, inspectors still had concerns which required monitoring and follow-up:

- embedding and training the new management team to ensure that the service provided was safe, appropriate, consistent and effectively monitored
- complaints follow up was not robust nor consistent
- maintenance and accessibility of the required records, such as training

records, staff files, staff roster and medication administration sheets
- providing mandatory and appropriate staff training for all staff
- culture change to be established
- staff performance improvement plans to be put in place
- staff supervision arrangements and line management systems to be set out
- medication management issues to be addressed and remedial action taken to prevent poor practice and protect residents.

The registered provider representative was required to submit:

- an updated improvement action plan as per the undertaking following the notice of proposal to cancel the registration of the centre
- further correspondence from the Ombudsman for older people in relation to a previous serious complaint and the outcome of the actions taken following a recent incident
- a timely, comprehensive and achievable compliance plan based on the findings of this inspection.
- An updated and correct training matrix and training plan in relation to essential areas of care as identified under Regulation 16: Staff training and Development, in this report.

In relation to fire precautions, there was a noticeable improvement in the oversight and management of fire safety risks. This was evident from the work completed in the centre and the assurance received from the registered provider representative in relation to the follow up of issues identified on this inspection.

Outstanding actions remained in the updated fire safety risk assessment for the centre. The inspector reviewed this with the registered provider representative and found that there was a plan in place for each outstanding action.

In conclusion, the findings of this inspection were that, while the centre was on a pathway to improvement, continued improvement and oversight was required on the part of the provider of Lystoll Lodge Nursing Home to ensure regulatory compliance and the provision of a safe and effective service for residents. At the feedback meeting following the inspection the new management team stated that they were committed to improving compliance with the aforementioned Regulations which specify the regulatory requirements for the management of a designated centre and the care and welfare of residents who reside there.

Regulation 14: Persons in charge

A new person in charge had been appointed since the previous inspection. She fulfilled the requirements of the Regulations and had the appropriate training and experience.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels had been increased since that previous inspection. Inspectors saw that staff members were kind and caring in their interactions with residents. Inspectors spoke with a number of staff who were well trained for their role and said they would have no hesitation in reporting any observed poor practice. New staff nurses were undergoing probation and these were seen to be kind to residents. Management staff were known to residents who felt empowered to talk with them and discuss issues of concern. Letters of a complimentary nature were seen by inspectors. These praised the staff, the management and the care provided.

However, a number of residents said that they felt rushed at times and that staff took a long time to respond to call bells. In addition, a resident had not got his meal with other residents. These events were indicators that staffing levels required ongoing review particularly in light of the high sickness level among all groups of staff. For example, inspectors found that on one weekend there had been only one staff nurse on duty for 44 residents. This was a high risk practice as supervision was not robust on these occasions, hence the risk of a resident missing a meal was higher and a medication documentation error was seen to have occurred.

Other examples of lack of staff in the upstairs section were seen as follows: Inspectors found that a resident in the upstairs sitting room appeared distressed and was perspiring. Inspectors were required to call a staff member to attend to the resident. In addition, an external contractor was observed to look for a staff member in the upstairs section, however, he was seen to have to go downstairs to locate a member of staff. Staff were seen to congregate in the staff office, downstairs, leaving areas of the home and the residents upstairs, unattended for periods of time. These were repeat findings, and were highlighted as significant due to the fact that there were residents with high needs and their visitors, requiring information and support, in this area.

Judgment: Not compliant

Regulation 16: Training and staff development

All the appropriate training had not been completed. For example:

- training on medication management and records of same
- training on identifying the clinical signs of deterioration in the frail resident
- training on supportive behaviour management and developing a person-centred culture of care
- training on comprehensive care planning

- a number of staff had yet to complete training on end of life care.
- training on supporting residents' rights to free movement and autonomy
- training on age appropriate and meaningful activities

In addition, staff appraisals were not undertaken as required and poor staff performance had not be consistently or adequately addressed for some members of staff: such as,

- the failure to order medicines when required
- repeated medicine errors from some staff
- not updating care plans
- not providing positive behaviour support for vulnerable residents.

Judgment: Not compliant

Regulation 19: Directory of residents

This was maintained in line with Regulatory requirements.

Judgment: Compliant

Regulation 21: Records

Inspectors found that not all records were maintained and accessible:

- not all staff files reviewed contained the documents required under Schedule 2 of the Regulations including verified and correct references as well as completed CVs (curriculum vitae)
- a record book of medication checks could not been found during the inspection
- training records were not easily accessible and not all training had been completed
- staff rosters were not readily available to inspectors and were not updated when changes had occurred to the worked roster
- lack of accurate, relevant and contemporaneous care planning documentation.

Judgment: Not compliant

Regulation 22: Insurance

Insurance documentation was available in the centre.

Judgment: Compliant

Regulation 23: Governance and management

A number of governance and management improvements were found by inspectors on this inspection:

- a number of safeguarding issues had been investigated
- staff meetings were now scheduled on a more regular basis to facilitate more effective communication in the team
- a return to work protocol had been developed to address the high sickness absence level
- staffing levels had been increased in the late evening
- the provider had engaged external training and advice to facilitate regulatory compliance
- fire safety works had been greatly advanced
- the management team had been augmented with a new person in charge, a new registered provider representative and two clinical nurse managers.

Despite the above improvements inspectors remained concerned in relation to fulfilling the tasks of :

- moving from a task-oriented culture to one of a person-centred culture for all staff
- staffing levels and effective staff training provision to include evaluation and learning from same
- audit and action plans
- complaints management and improvement plans
- embedding the new team and role definition for managers and supervisors
- staff appraisal and supervision
- maintaining the fire safety records, the fire drills and the improved practices.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contracts were in line with the Regulatory requirements. The cost of additional therapies and activities were outlined and the residents had been assigned room numbers on admission.

Judgment: Compliant

Regulation 3: Statement of purpose

This document was available in the centre.

Following review by inspectors it was found to require further attention in relation to inserting the number of showers available to residents and to specify which residents availed of each shower room.

The new management arrangements were required to be inserted in the statement of purpose also.

Judgment: Substantially compliant

Regulation 30: Volunteers

The required files were maintained for volunteer staff.

Judgment: Compliant

Regulation 31: Notification of incidents

The required incidents had been notified to the Office of the Chief Inspector since the previous inspection.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints had not all been addressed in a consistent manner. The satisfaction of all complainants had not been recorded as required. The records in relation to complaints were not cohesively maintained. Records relating to complaints were maintained in different files, sometimes on loose sheets of paper, which made it difficult for inspectors to ascertain the stage of each complaint and the integrity of records.

Inspectors found that there was lack of evidence that an action plan, which had

been proposed following findings of an investigation into a complaint, had been instigated.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A number of Schedule 5 policies reviewed by inspectors had been updated.

Judgment: Compliant

Quality and safety

Findings on this inspection were that the quality and safety of care required a system of robust and consistent management, which inspectors found was not fully established in the centre. Increased supervision and defined areas of responsibility had yet to be assigned. This meant that inspectors could not yet be assured that the development and maintenance of new quality and safety systems would be maintained.

On this inspection, inspectors found some improved supervision. However, similar to previous inspection findings staff nurses did not always maintain a presence upstairs which was a key component in establishing staff and resident supervision for the cohort of residents there. This was detailed under Regulation 15: Staffing, under the Capacity and Capability section of this report. In relation to the provision of meaningful activities inspectors found that some staff members were very enthusiastic in regards to providing activities such as reading, knitting, card games and music. Not all activities were age appropriate however such as "colouring" and not all residents were seen to be happy with this task, which did not appear to be organised or explained in a suitably adult manner. This was addressed in more detail under Regulation 9 in this report.

On this inspection, inspectors found that there were gaps in the care plan documentation for residents. For example, two residents had returned from hospital and their care plans had not been reviewed or updated in accordance with their changed needs. This was important as the residents had altered mobility and altered cognitive status since discharge from hospital. Moreover, a residents with altered communication and very specific behaviour needs did not have appropriate plans in place to support carers in the correct approach to avoid any distress. Further detail on this finding was specified under Regulation 5 in this report.

A number of unresolved concerns in relation to health-care were again reviewed on this inspection. Further correspondence from the ombudsman for Older People in

relation to these events were required to be submitted to the Chief Inspector in the interests of transparency. Inspectors found that following one complaint the appropriate training had yet to be provided to all staff members. This was necessary in order to raise awareness of the needs of residents and families at a specific time in their lives and to avoid a repeat of the distress felt by family members when optimal care was not provided, as on the previous occasion.

In relation to medicine management, similar to findings on all previous inspections a significant concern remained in relation to the absence and verification of the signatures of a number of nurses who checked or administered medicines. Documentation in relation to medication management was found to have gone missing, similar to previous inspection findings. This finding remains non-compliant since the previous inspections. Practices were found to be in contravention of the guidelines set out for nurses in An Bord Altranais, ''Guidance to Nurses and Midwives on Medication Management'' 2007 and of the guidelines in the centre's own policy on medicine management. These issues were highlighted in more detail under Regulation 29: Medicines and Pharmaceutical Services. As found on previous inspections, clinical governance awareness, increased supervision, adequate training and follow up with a comprehensive audit was required to adequately reduce the risk presented by poor practice on behalf of some staff. These measures were necessary to ensure the safety of residents and the safe provision of medication.

As before, improvements were acknowledged in relation to the fact that medicine errors were now being recorded and a system of audit had been rolled out, even though inspectors found that it required further development to become useful in informing learning and improvement in compliance for some staff.

Infection control had improved. Issues such as correct hand-washing technique and the use of personal, protective equipment (PPE) had increased and staff were found to be aware of infection control best practice.

Inspectors found that the risk register was up to date and well maintained. A number of risks had yet to be addressed however.

While safeguarding of residents was supported by training and appropriate policies on the prevention, detection and response to abuse.
nevertheless, inspectors found that an investigation into an allegation of an abusive interaction had not been followed up with appropriate actions. Significant concerns relating to this aspect of resident care had been detailed under Regulation 8: Protection, in this report.

Fire precautions was reviewed by a specialist inspector of estates and fire safety and it was found that the registered provider had taken measures to significantly improve the level of fire safety both in terms of the physical building and the practices in place. Inspectors found that significant progress had been made in relation to the findings on fire safety deficits which were found on an inspection carried out on 3 April 2019 by the fire safety inspector from the office of the Chief Inspector. Engagement between the provider and the Office of the Chief Inspector

was ongoing in relation to completing these works. Findings from this inspection and issues to be addressed were highlighted under Regulation 28 in this report.

Improvements were evident by the work that had been carried out to the building, both visible and concealed. The extent of the work was described to the inspector which provided assurance that the risk of fire had significantly reduced and residents were now in a safer environment. The first floor was now adequately subdivided into fire compartments to facilitate the identified method of evacuation; phased horizontal evacuation. The provider had submitted to the Chief inspector's office, confirmation from the fire consultant that this work was completed to a satisfactory standard. Further to advice received from the person who delivers fire safety training, the registered provider representative committed to provide additional fire blankets in each wing of the building and to purchase evacuation chairs in addition to the evacuation ski sheets they have fitted to all residents' beds in the centre. There was a clear system in place to determine who was in charge in terms of making decisions if a fire should occur. This was evident from staff spoken with during inspection. It was noted that the name of the person who would take charge during a fire was displayed on the staff notice board for each shift and annotated on the staff rota.

However, the inspector was not assured that the fire rated ceiling throughout the first floor created an effective barrier to the spread of fire and smoke and that service penetrations, extract ducting etc passing through the fire rated ceiling were adequately fire protected, with fire dampers and collars fitted as maybe necessary. The registered provider representative confirmed that they would request confirmation from their competent person in this regard. The fire detection and alarm system was a category L1 type system, which provides fire detection coverage to all areas of the building, including attic spaces. However the fire detection and alarm system zones did not align with the fire compartments provided within the centre provided as areas of relative safety as part of the phased evacuation procedure. This meant that in the event of a fire, there could potentially be a delay in identifying the area in which the fire had started. Furthermore, there was no zoned floor plan adjacent to the panel to assist staff in identifying the location of fire in the event of the fire alarm activating. This required review. The risk associated with the storage of combustible materials along escape routes had not been addressed. This was a repeated finding. The inspector observed storage presses along escape corridors which were not enclosed in fire rated construction. Furthermore, storage was found within the escape stairway enclosures. The registered provider representative provided assurance that the storage presses would be emptied and removed the following day. The storage within the escape stairway was immediately removed during the inspection. The inspector found that the needs of residents in the event of a fire were assessed in the form of a personal emergency evacuation plans (PEEPs), however improvements were required in this regard. The inspector noted that where one resident who had returned from a stay in hospital, the assessment of their evacuation requirements had not been updated. In the main, escape routes were kept clear and free of obstruction. The inspectors noted one instance of a partial obstruction of an escape route. This was immediately addressed during the inspection.

Overall the quality and safety of care required continuing review to achieve compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). A period of time was required to embed the new governance and management arrangements in order to enable inspectors to evaluate and assess the actions taken and their impact on the quality of life and safety of residents living there.

Regulation 11: Visits

Visitors stated that they were welcome throughout the day. Residents confirmed this and inspectors spoke with a number of the relatives who were sitting with residents in both sitting rooms.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had space for their personal items and sufficient clothing. Rooms were, on the whole, personalised and nicely decorated.

Judgment: Compliant

Regulation 13: End of life

Inspectors found that despite complaints in relation to inadequate support and care at end of life the staff had not been afforded training in this aspect of care. As a result, inspectors could not be assured that all staff were aware of best practice in holistic end-of-life care to include emotional support for all involved.

It was not clear to inspectors if residents wishes in relation to their care at this time had been recorded, as a key sample of "end-of-life" care plans were seen to be blank. Moreover, where decisions had been made previously these were not all updated, post hospital admission nor reviewed on a consistent basis.

Judgment: Not compliant

Regulation 17: Premises

The premises was spacious and well decorated. However, the provision of shower facilities required review as one shower was out of order and a second bathroom was in use as a laundry room. This meant that there were only four, shared showers available for all 48 residents. This was in contravention of the 'National Standards for Residential Care Settings for Older People in Ireland' 2016 which set out a minimum of one shower to be provided for every eight residents. This limited residents' choice particularly those who would like more than one shower per week. In addition, one of the showers was located in the bathroom in the upper hallway which, by it's location, lacked privacy for residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were praiseworthy of the food available. There was access to the dietitian and the speech and language therapist. Home baking was available and the dining space was adequate for residents.

Judgment: Compliant

Regulation 26: Risk management

The risk register was seen to be maintained and updated regularly. Some risks had yet to be identified such as the risk of a resident's meal being omitted as outlined under Regulation 18 above and the risk of a resident being given the wrong medication, such as insulin. The choking risks for a resident who did not wish to adhere to the speech and language (SALT) guidelines in relation to the need for a specific modified diet had not been assessed.

Judgment: Substantially compliant

Regulation 27: Infection control

Issues in relation to infection control had been addressed on this inspection. The management team had access to an infection control expertise and a resident who had contracted an infection was seen to be suitable cared for in a protective environment.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had taken measures to significantly improve the level of fire safety both in terms of the physical building and the practices in place.

The registered provider did not take adequate precautions against the risk of fire;

- The risk associated with the storage of combustible materials along escape routes had not been addressed. This was a repeated finding.

The inspector was not assured that adequate arrangements had been made for detecting and containing fires:

- the inspector was not assured that the fire rated ceiling throughout the first floor created an effective barrier to the spread of fire and smoke
- The fire detection and alarm system zones did not align with the fire compartments provided within the centre provided as areas of relative safety as part of the phased evacuation procedure
- There were no zoned floor plans adjacent to the fire alarm panel to assist staff in identifying the location of fire in the event of an activation of the fire alarm.

Adequate arrangements had not been made for evacuating, where necessary in the event of a fire, of all persons in the designated centre:

- The inspector noted that where one resident who had returned from a stay in hospital, the assessment of their evacuation requirements had not been updated.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found repeat findings in this vital aspect of residents' nursing care needs.

While staff informed inspectors that most of the general practitioners (GPs) attended the centre when requested, inspectors found that not all medications were charted on the MAR (medicine administration record), which staff used as their prescription. This meant that staff were administering some medicine without a valid prescription in the centre. This was significant as one resident had a sore mouth and was awaiting a medicine to be ordered from pharmacy. This resident was awaiting a prescription for a nutritional supplement. These medicines were procured following intervention by inspectors. Furthermore, inspectors checked a medicine which was prescribed for a resident who had returned from hospital. It was found that four of

the tablets involved had not been given as prescribed. This was a very serious omission as the medicine was a preventative medicine related to the medical crisis which had resulted in hospitalisation.

When PRN (give as required) sedative medications were administered to a resident staff had not recorded the reason or rational for administering the medicine in line with best evidence-based practice. In addition, behaviour support plans were not in place to outline alternatives to the use of the sedation. This documentation and evaluation was necessary to maintain the good quality of life of residents. Inspectors found that a number of these medicines no longer in use had not been returned to pharmacy as required by legislation.

A serious medicine error had occurred in relation to the administration of a medicine which could have had serious consequences. Inspectors were not assured that all staff were aware of their professional responsibilities in relation to the recording and administration of medicinal products.

MDA (controlled drugs, such as morphine) were not properly accounted for nor recorded in the centre. Inspectors were informed that a record book in relation records of these medicines had been missing for a number of weeks prior to the inspection and had not been replaced. This meant that records of the stock of these drugs had not been recorded and consequently was not available to inspectors for review. Inspectors found that errors had occurred with these medicines and additionally, inspectors found that medicine of this type was still in stock, even though it was no longer required in the centre and should have been returned to the pharmacy. Best evidence practice and medicine guidelines for nurses state that these medicines should be accounted for on every shift when the nurse on duty handed over the medicine keys to the incoming nurse. Deviation from best practice was a repeat and very serious finding in the management of medicines in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans for most residents with low dependency needs were seen to be updated and were detailed. Nevertheless, this was not the case for all residents particularly those with more complex needs. As already stated in this report residents who had returned from the acute setting had no updated care plans in place to support staff to meet the changed needs of these residents. For example, there was no care plan in place in relation to a resident who had an ulcerated mouth nor complete care plans for residents with behaviour issues or for a resident with a urethral catheter.

Care plans were not updated when residents returned from hospital with changed needs. Inspectors found that the staff on duty on the day of re-admission of the residents involved had not updated the care plans in line with the Regulatory

requirements under Regulation 5 (4) for review of the care plan. This was significant as health care issues such as mouth care, mobility, evacuation plans, fluid intake and nutritional needs were not re-assessed or communicated to other significant staff. The absence of a fluid intake record for example, meant that staff were not able to evaluate or communicate with other staff about the fluid balance requirements of vulnerable residents who were confined to bed or to their room due to illness or infection.

Judgment: Not compliant

Regulation 6: Health care

Allied health services were accessible and physiotherapy was available on a weekly basis at a reasonable cost.

However, not all health-care needs were met on a timely basis as discussed under Regulation 5: Care Plans and Regulation 29: Medication.

This impacted on the comfort and well-being of residents involved.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Care plans in behaviour support were not in place. Residents with specific needs in relation to their behaviour required robust and detailed care plans in order for staff to support them to manage their responses to the environment and to staff approaches. Furthermore, residents who exhibited behaviour changes did not have a best evidence-based tool in place to describe and plan the strategies for supportive behaviour management (for example, the ABC chart, Antecedent, Behaviour and Consequence), which was designed as a method to describe the behaviour in an objective manner.

Not all staff had received appropriate training to support such residents.

This was particularly important as a resident who required careful management due to her declining cognitive abilities and associated anxieties did not have her comfort measures set out in a plan of care to guide staff interactions. This had resulted in an incident which was distressing to all involved in particular the vulnerable resident. There was evidence that sedative medication had been administered without corresponding documentation to indicate why, and if, there were alternative comfort or distraction methods employed to minimise the use of this medicine to manage the behaviour.

Judgment: Not compliant

Regulation 8: Protection

A number of concerns raised indicated that not all staff were aware of what constituted verbal and psychological abuse. Inspectors formed the view following a review of reports and investigations that these issues were not adequately addressed and that staff had not applied learning from training to each event. Consequently inspectors were not assured that the available training was adequate to address the issues raised. In addition, staff supervision and reporting of unacceptable behaviour required enhancement to protect residents. For example, residents had complained of rushed care, being dressed ''in a temper'' and not given a bell prior to the carer leaving the room, as well as a poor ''attitude'' on the part of a small number of staff.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents said that they were supported to vote and that they were enabled to access the local town for events such as the races, and the literary festival. They said they were afforded choice at mealtimes and in relation to bedtimes. In addition, residents had access to daily newspapers, TV and radio.

Not all residents were afforded freedom of movement. Some institutional practices were seen such as residents being asked to sit when they clearly had an urge to walk around. In addition, not all activities were age appropriate or resident-centred.

Residents had access to a small secure courtyard. However, one resident was seen to be stopped from going outside to a secure garden area. This action was not supported by a risk assessment to indicate why this occurred. A staff member did not make themselves available to assist the resident to walk outdoors.

Some members of staff were very enthusiastic about the activity programme and it was obvious to inspectors that a lot of time and care had been put into the formation of a suitable programme. Continuity of the programme on a daily basis was not guaranteed however.

Inspectors found that residents had no choice in relation to the early teatime arrangements. Tea time commenced at 16.15 which meant that there was a very long evening ahead before the evening snack at 20.00. As this was a two-storey building inspectors found that a more robust supervisory approach was required to ensure that all residents were given their meals at each meal time. For example,

inspectors found that there had been a concern raised by one resident when he had to request his meal after the assigned meal time. This omission would have had a serious impact if the resident had been cognitively impaired.

In addition, as highlighted under Regulation 18: Premises, there was a lack of sufficient showers in the centre which impacted on residents' privacy and dignity as they were not all proximal to residents' bedrooms. For example, the shower which was out of order at the time of inspection was located in a wheel chair accessible bathroom in the main entrance hall.

Judgment: Not 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0027363

Date of inspection: 03/10/2019

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: An additional Clinical Nurse Manager has been recruited who will be commencing post on 18.11.2019. Two senior staff nurses have been recruited both of whom are currently undergoing pre employment checks. Five additional health care assistants have been recruited also, two of whom are currently undergoing pre employment checks. An allocation roster is now completed daily at morning handover, outlined within this allocation roster are the duties and responsibilities of each care staff member and it is identified which individual staff member is responsible for each of the identified tasks. Within the allocation roster it is identified that a staff nurse is assigned upstairs and downstairs. This allocation is reviewed by the PIC throughout the day to ensure it is being adhered to. A meal checklist is now completed for each resident to ensure they have received their food at the correct time. A second checklist is also completed by kitchen staff. The Senior Health Care Assistant on duty each day is responsible for ensuring that this is completed correctly.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training on medication management and records of same – scheduled 21.11.2019 • Training on identifying the clinical signs of deterioration in the frail resident - scheduled 29.11.2019 • Training on supportive behaviour management and developing a person-centred culture of care – scheduled 10.12.2019 and 13.12.2019 • Training on comprehensive care planning – scheduled 19.11.2019 and 22.11.2019	

• Training on end of life care – completed on 26.06.2019
• Training on supporting residents' rights to free movement and autonomy scheduled 10.12.2019 and 13.12.2019
• Activities co ordinator has completed training regarding activity engagement
• Additional training on age appropriate and meaningful activities – a course in “engaging activities for older adults “ has been scheduled for the activities co ordinator.
• Appraisal schedule completed for all staff, appraisals will be completed quarterly.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Comprehensive Employment History forms have been issued to all staff; staff have been instructed to complete these in full and return to RRP.
RRP is currently conducting an audit of staff files with particular reference to employment references, the audit and identified actions for same are due for completion week beginning 16.12.2019
Local training records have been updated to include all up to date training received and a centralized system has been developed to ensure this continues going forward.
Planned and Actual rotas are updated daily as required by the RRP and are available for review at all times.
Care Planning training has been scheduled for nursing staff on 29.11.2019.
The PIC is also conducting care plan audits on a weekly basis.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
New Positive Behaviour Support Policy has been developed and staff will receive training for same on 10.12.2019 and 13.12.2019.
Reflective practice statements completed by all staff following any incident with the home.
Positive Behaviour Support plans are being developed for those residents who require additional support.
These are being completed in conjunction with the resident, their next of kin and the staff who support them on a daily basis.
The PIC is notified of all complaints received by the nursing home; the PIC reviews the complaint and identifies appropriate resolution in conjunction with the complainant.
RRP conducts monthly audit of complaints, ensures that all actions have been completed and consults with the complainant to ascertain if they are satisfied with the resolution.
Scheduled team meetings occur six weekly, with management meetings occurring on a weekly basis.
New job descriptions have been issued to all staff which clearly identifies roles and responsibilities and the reporting structure within the nursing home.
A code of conduct has also been issued to staff.

A quarterly schedule of supervision and appraisal is in place for clinical staff to offer continuing support and guidance.
New staffs receive a two week period of induction.
RRP conducts a monthly audit of fire safety documentation to ensure that it is up to date and correct.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
An updated Statement of Purpose and Function will be completed by the RRP by Friday 22.11.2019 and forwarded to the Regulator.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The PIC is notified of all complaints received by the nursing home; the PIC reviews the complaint and identifies appropriate resolution in conjunction with the complainant.
RRP conducts monthly audit of complaints, ensures that all actions have been completed and consults with the complainant to ascertain if they are satisfied with the resolution.

Regulation 13: End of life	Not Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
End of Life Training had been completed with staff on 26.06.2019.
A refresher of this course will be scheduled and completed by 20.12.2019

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Additional shower has been added to the premises, this was completed on 15.11.2019

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The risk register has been updated to include identified risks and will continue to be reviewed by the PIC.
Completed 8.11.2019

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Storage in the escape routes has been removed.
The Fire Engineer has visited the home to assess the fire rated ceiling throughout the first floor and is satisfied that it is an effective fire barrier. He will issue documentation to the regualtor to confirm same.
Fire mastic has been used in the case of minor penetrations as noted by the inspector – completed 15.11.2019.
The Fire Alarm Panel consultant has also visited the centre and has confirmed that the fire compartments within the home are now aligned with the zones identified in the fire panel.
CAD drawings which reflect this are being prepared at present by the competent person, these drawings will be completed by 20.12.2019

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All MARS have been reviewed and updated by the relevant GPs.
Weekly medication audits are being carried out by the PIC and/or her delegates to ensure that medication management guidelines are being adhered to.
Risk assessment in place regarding medication errors, a copy of which is on each drug trolley
PRN effects record sheet is now completed when a PRN medication is administered to a resident.
Positive Behaviour Support plans are in development for residents who exhibit behaviours of concern.
A Positive Behaviour Support policy has also been developed which will be discussed with staff during workshops on 10.12.2019 and 13.12.2019.
The addition of a third clinical nurse manager on 18.11.2019 will provide additional clinical oversight to the staff nurse team.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Training on comprehensive care planning – scheduled 19.11.2019 and 22.11.2019

The PIC is also conducting care plan audits on a weekly basis.
Fluid intake and output charts are also in place for residents who require them and these are monitored daily by the nursing staff.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Care Planning training has been scheduled for nursing staff on 29.11.2019.
The PIC is also conducting care plan audits, any identified under performance found in these audits is being addressed under the Disciplinary Policy.
Weekly medication audits are being carried out by the PIC and/or her delegates to ensure that medication management guidelines are being adhered to

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Positive Behaviour Support plans are being developed for those residents who require additional support.
These are being completed in conjunction with the resident, their next of kin and the staff who support them on a daily basis.
A Positive Behaviour Support policy has also been developed which will be discussed with staff during workshops on 10.12.2019 and 13.12.2019.
The RRP will conduct a review of the restrictive practices within the home with the aim of using minimal restrictions where all other alternatives have been considered
This will be complete by 31.12.2019

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Safeguarding of residents is discussed at all staff meetings.

Role play will form part of staff meetings also to support understanding of Safeguarding and Protection in a practical context.
A code of conduct has also been issued to staff.
A quarterly schedule of supervision and appraisal is in place for clinical staff to offer continuing support and guidance.
New staffs receive a two week period of induction.
Additional training will be scheduled and provided to staff by 31.12.2019 on the topic of safeguarding and resident protection.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
An allocation roster is now completed daily at morning handover, outlined within this allocation roster are the duties and responsibilities of each care staff member and it is identified which individual staff member is responsible for each of the identified tasks.
Within the allocation roster it is identified that a staff nurse is assigned upstairs and downstairs. This allocation is reviewed by the PIC throughout the day to ensure it is being adhered to.
A meal checklist is now completed for each resident to ensure they have received their food at the correct time. A second checklist is also completed by kitchen staff.
Tea time will be held at 5pm from 01.12.2019 with the option of residents having food later in the evening if they so wish
The Senior Health Care Assistant on duty each day is responsible for ensuring that this is completed correctly.
Positive Behaviour Support plans are in development for residents who exhibit behaviours of concern.
A Positive Behaviour Support policy has also been developed which will be discussed with staff during workshops on 10.12.2019 and 13.12.2019.

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Not Compliant	Orange	18/11/2019
Regulation 13(1)(c)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the family and friends of the resident concerned are, with the resident's consent, informed of the resident's condition, and permitted to be with the resident and suitable	Substantially Compliant	Yellow	18/11/2019

	facilities are provided for such persons.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/12/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/12/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	18/11/2019
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	18/11/2019
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief	Not Compliant	Orange	31/12/2019

	Inspector.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	18/11/2019
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	31/12/2019
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	08/11/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording,	Substantially Compliant	Yellow	18/11/2019

	investigation and learning from serious incidents or adverse events involving residents.			
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	31/12/2019
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/12/2019
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		15/11/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	18/11/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	22/11/2019
Regulation 28(2)(iv)	The registered provider shall	Substantially Compliant	Yellow	18/11/2019

	make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 29(3)	The person in charge shall ensure that, where a pharmacist provides a record of medication related interventions in respect of a resident, such record shall be kept in a safe and accessible place in the designated centre concerned.	Not Compliant	Orange	18/11/2019
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	18/11/2019
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been	Not Compliant	Orange	18/11/2019

	dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	22/11/2019
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Yellow	18/11/2019
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints	Not Compliant	Orange	18/11/2019

	procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	18/11/2019
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Substantially Compliant	Yellow	18/11/2019
Regulation 34(2)	The registered provider shall	Substantially Compliant	Yellow	18/11/2019

	ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	18/11/2019
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	18/11/2019
Regulation 5(3)	The person in charge shall prepare a care	Substantially Compliant	Yellow	18/11/2019

	plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/12/2019
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	18/11/2019
Regulation 6(2)(b)	The person in	Substantially	Yellow	18/11/2019

	charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Compliant		
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/11/2019
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	18/11/2019
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	18/11/2019
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation	Substantially Compliant	Yellow	31/12/2019

	to the detection and prevention of and responses to abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Yellow	18/11/2019
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	18/11/2019
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Yellow	18/11/2019
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.	Not Compliant	Orange	18/11/2019
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	18/11/2019
Regulation 9(3)(e)	A registered provider shall, in	Substantially Compliant	Yellow	18/11/2019

	so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.			
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.	Substantially Compliant		18/11/2019
Regulation 9(4)	The person in charge shall make staff aware of the matters referred to in paragraph (1) as respects each resident in a designated centre.	Not Compliant	Orange	18/11/2019