Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

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:	08 May 2019
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0027021

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
08 May 2019	19:30hrs to 23:00hrs	Mary O'Mahony	Lead
09 May 2019	09:30hrs to 16:45hrs	Mary O'Mahony	Lead
08 May 2019	19:30hrs to 23:00hrs	John Greaney	Support
09 May 2019	09:30hrs to 16:45hrs	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. They said that their bedroom accommodation was suitable and spacious. Staff were reported to be kind.

They said that their visitors were welcome and there were private areas available in which to chat with them. They enjoyed coming together from both floors for meals in the spacious dining room. meals were a social event and they said that the meal times were unhurried and relaxing.

Residents were facilitated to attend a range of activities and staff were enthusiastic when delivering the sessions which had increased since the previous inspection.

Residents were aware of the complaints process and they had resident meetings at which they could express concerns or opinions on issues pertinent to the centre and to their care.

Inspectors found that there were a number of complaints recorded which indicated that a number of concerns had been raised by relatives of sick residents who felt that their relative did not receive optimal care at key illness moments in their lives.

Capacity and capability

This unannounced inspection took place in light of concerns of the office of the chief inspector for the safety and quality of life of residents and the registered provider's failure to progress in putting suitable systems in place to protect residents. Lystoll Lodge Nursing Home had an established record of repeat non-compliance with regulations and inadequate provider responses to the actions from the four inspections completed since 7 November 2018: namely the inspections of 07/11/18, 04/02/19, 03/04/19. The registered provider representative (RPR) had previously attended meetings, as a means of engagement under internal regulatory escalation processes, at the office of the Chief Inspector when the registered provider was issued with a warning letter and informed of the potential consequences of continuing and ongoing non-compliance.

The findings from this unannounced inspection of 8 and 9 May 2019 demonstrated a lack of substantial progress in addressing non compliance. The provider (Lystoll Lodge Nursing Home Limited) had failed to address the deficits in governance and management particularly in relation to recruiting and appointing a person in charge. The registered provider did not have systems in place or demonstrate a

capability to monitor, identify poor practice and respond to poor performance.

The registered provider had not taken due diligence in the appointment of a person in charge that met regulatory requirements. Since the resignation of the previous person in charge in place at the previous inspection, the registered provider had appointed two persons to the role, neither of whom met the regulatory requirements of of Regulation 14: Person in Charge. The absence of an effective system of governance was evident in the recruitment of a suitably qualified person in charge. This breach of the Regulations indicated that the registered provider had poor understanding of their regulatory responsibilities.

Inspectors remained concerned that the registered provider had failed to set out a clearly defined management structure. In the absence of role definition and suitable personnel, good clinical governance could not be maintained. Staff improvement initiatives such as safe medication management and supervision, which had progressed under the guidance of the previous person in charge, had not been maintained: for example: inspectors found poor auditing systems in relation to medication management, poor complaints management and a lack of adequate staff supervision which led to reports of alleged abusive interactions between staff and residents. This will be addressed in the Quality and Safety dimension of this report.

Some improvements were outlined by registered provider:

· A number of safeguarding issues were investigated, however follow up actions remained outstanding.

· Residents' personal bank accounts were now in place.

· Staff meetings were more frequent than previous which ensured more effective communication.

· The return to work protocol had resulted in improved sickness levels.

· Staffing levels had increased with individual accountability for medicine management being audited.

· The provider had engaged an external company to facilitate regulatory compliance and support staff in knowledge of the Regulations and Standards.

· Fire safety works had been progressed.

Most of the records and documentation as required by Schedule 2, 3 and 4 of the Regulations were maintained in the centre. Residents' records such as care plans, assessments, medical notes and nursing records were, on the whole, relevant to the care of the individuals concerned.

Not all records were available to inspectors:

· there was no curriculum vitae (CV) present for one staff which was required

under Schedule 2 of the Regulations

· a medication audit record was not available

· fire safety checks were not all complete

· some signatures were not present where medicines had been checked and administered

· half hourly fire safety patrols, (necessary while undergoing fire safety upgrades) had not been documented for a period of two weeks

In summary, despite a number of improvements, which were acknowledged with staff and the provider, inspectors still had serious concerns in relation to:

· the fact that on two occasions the provider had employed a person to undertake the role of person in charge even though the person did not fit the regulatory requirements for the role

· investigation follow up was not sufficiently robust

· staff disciplinary policy was not followed for a number of incidents

· performance improvement plans were not in place where necessary

In conclusion, the findings of this inspection were that the provider had failed to take comprehensive steps to strengthen the governance and management of this centre for the purpose of improving the quality of life for residents, and supporting and supervising the staff in striving to achieve person-centred care and regulatory compliance.

Regulation 14: Persons in charge

The person who was employed to act as person in charge did not fulfil regulatory requirements.

Judgment: Not compliant

Regulation 15: Staffing

Staff numbers had been increased particularly in the early night up to 10pm. The provider was asked to keep staffing levels under review for the early night due to the changing needs of residents and the centre layout over two floors.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training had been rolled out in mandatory areas, however a number of issues regarding staff supervision remained outstanding:

- investigation follow up was not sufficiently robust,
  staff disciplinary policy was not followed for a number of incidents,
  performance improvement plans were not in place where necessary.

Judgment: Not compliant

Regulation 21: Records

- there was no curriculum vitae (CV) present for one staff which was required under Schedule 2 of the Regulations
- medication audit record was not available
- fire safety checking records were not all maintained
- some signatures were not present where medicines had been checked and administered
- half-hourly fire safety patrols, (necessary while undergoing fire safety upgrades) had not been documented for a period of two weeks
- the records required to be maintained for residents under Schedule 3 (b), (c) and (d) did not always accurately reflect the medical condition of residents.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors still had significant and serious concerns in relation to:

- the fact that on two occasions the provider had employed a person to undertake the role of person in charge even though the person did not fit the regulatory requirements for the role

- investigation follow up was not sufficiently robust nor timely
- audits were not followed by actions and learning from the findings
- staff disciplinary policy was not followed for a number of incidents
- performance improvement plans were not in place where necessary
- any improvements were not sustained and issues were addressed in a reactive way instead of taking a proactive approach.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose required updating and resubmission to the office of the Chief Inspector in relation to the names of key management personnel.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications had been submitted for the relevant incidents recorded in the incident book seen by inspectors.

Judgment: Compliant

Regulation 34: Complaints procedure

A number of complaints were related to staff interactions and omission of care.

These were still under investigation at the time of the incident.

The follow up and outcome from complaints was not followed up in a timely manner with the complainant.

This meant that the learning from complaints was delayed, staff were not supported with performance improvement plans and the complainants were left with a stressful situation for an extended period of time.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were seen to be kept up to date.

However, not all policies were adopted and implemented such as the policy on medicine management and on the prevention of elder abuse.

This was a repeat non compliance.

Judgment: Substantially 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. There was lack of supervision, role definition and defined areas of responsibility between senior managers and nursing staff, which impacted negatively on the roll out, development and maintenance of new quality and safety systems. External personnel had been engaged by the provider to provide expert advice of how to develop and maintain meaningful governance and management arrangements and practice.

On this inspection, inspectors found improved supervision on the upper floor of the centre. Staff nurses maintained a presence upstairs and activity provision was recorded on notice boards which were updated daily. Residents were seen to be meaningfully occupied on both floors of the centre, with reading, knitting, card games, visitors and music throughout the inspection. Residents had comfortable, spacious accommodation with en-suite showers and toilets. Premises maintenance issues had been addressed since the previous inspection and improvement works were on-going.

Inspectors found that residents' health care needs were met to a good standard according to residents, relatives and documents reviewed. Care plans were individualised. Most of the general practitioners (GPs) attended the centre when requested. Allied health services were accessible.

A number of concerns remained which were also found on previous inspections which indicated that not all relatives were happy that residents' health care needs were met as addressed under Regulation 6: Health Care, in this report. A report into the investigation into one such detailed concern had yet to be submitted to the Chief Inspector. A similar concern raised by another relative had not been adequately addressed in relation to the management of staff involved, end of life care in the centre and staff communication and responsiveness. This was addressed under

Regulation 13: End of Life Care.

An improvement found by inspectors on this inspection, related to the fact that detailed records were maintained in the centre in relation to these events and some attempts had been made to address the issues involved.

In relation to medicine management, similar to findings on the previous inspection a significant concern remained in relation to the absence and verification of the signatures of a number of nurses who checked or administered medicines. This was 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, evaluation of the understanding of training and a comprehensive ongoing, transparent audit was required to adequately reduce the risk presented by poor practice. These measures were necessary to ensure the safety of residents and the safe provision of medication.

Improvements were acknowledged in relation to the fact that medicine errors were being recorded and a system of audit had been rolled out even though it required further development to become useful in informing learning and improvement in practice and compliance.

Management staff stated that 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.

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 related to this aspect of resident care had been detailed under Regulation 8: Protection, in this report.

Improvements had been undertaken in the area of fire safety. Seals on the fire-safe doors had been replaced, attics had been made fire safe, staff were undertaking regular fire drills and all residents had a ''ski sheet'' and a personal emergency evacuation plan (PEEPs) in place. A fire safety risk assessment of the designated centre had previously been carried out by a competent professional with suitable experience in fire safety. This assessment had identified and rated fire risks throughout the centre. These were being addressed. Inspectors found that significant progress had been made in relation to the findings on fire safety deficits, as found on an inspection carried out on 3 April 2019 by the fire safety expert inspector from the office of the Chief Inspector. Engagement between the provider and the Office of the Chief Inspector was continuing, in relation to these works.

On this inspection, inspectors found that the risk register was being maintained. Some risks had yet to be adequately assessed as addressed under

Regulation 26 in this report.

Inspectors found overall, that the quality and safety of care required robust management and supervision which had nor been established in this centre.

Regulation 12: Personal possessions

There was adequate space in the centre and in bedrooms for the storage of residents' clothes and personal possessions.

Judgment: Compliant

Regulation 13: End of life

A concern raised by a relative had not been adequately addressed in relation to staff involved in the care at end of life; particularly in relation to pain relief, staff response times and responsiveness to needs of both residents and relatives. End of life training had not been reassessed or updated in light of these findings.

Judgment: Not compliant

Regulation 17: Premises

Premises had been decorated and painted. New windows were being installed throughout. Fire safety systems were being upgraded.

Judgment: Compliant

Regulation 18: Food and nutrition

Food was plentiful and residents were happy with the choices.

There was a qualified chef in the centre.

Staff were aware of the specific dietary needs of residents.

Judgment: Compliant

Regulation 26: Risk management

Risks were assessed and the register had been updated on a regular basis.

However, inspectors found that he risks for residents who were at risk of choking had not been assessed in the risk register.

The seriousness of the risk was not sufficiently highlighted to staff. For example, the first aid kit was not readily available as well as items such as the suction machine if required.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was clean and staff were seen to use correct hand washing technique and wear personal protective equipment.

Judgment: Compliant

Regulation 28: Fire precautions

Half-hourly patrols of the centre had not been documented for two weeks while the registered provider had been absent. This check was required until the fire safety works had been completed.

In addition, fire safety checks had not been completed for those two weeks, ie checking of fire exits, setting off the fire alarm and checking fire doors.

Fire safety works, required to upgrade the fire safety systems, were almost completed at the time of the inspection.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

- Signatures were still not present on all daily and nightly checks of the controlled drugs in the book supplied. This resulted in the count of pain relieving patches being incorrect: for example, staff had found that two extra patches were present following one count. The source of the error had yet to be found. The counting of this medication at the change over of each shift by two staff members was the required control to prevent such errors.
- Signatures were not present on all medicine administration sheets (MAR).
- Audits of medicine management sheets (MAR) which were seen by inspectors on day one of the inspection could not be found for review by inspectors on day two of the inspection.
- There was no follow-up and action plans in place for previous medication audits which indicated a number of administration signature omissions.
- While medication competence audits had been carried out for relevant staff under the guidance of the previous person in charge these had not been continued with the result that standards had slipped again in this key area.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of care plans were reviewed. Inspectors saw that these care plans were generally well maintained.

However, according to a complaint seen it was not evident that all care plan entries corresponded with residents' care needs at the time of writing the report.

Judgment: Substantially compliant

Regulation 6: Health care

- Residents generally could access their general practitioner (GP).
- Not all GPs reviewed the medications on a regular basis which staff found difficult to address. Staff generally brought the MAR sheets to the doctor's office for updating and signing.
- Residents had regular access to allied health professionals such as the physiotherapist, the psychiatric services, the dietitian and the speech and language therapist (SALT)
- Very serious concerns remained which were also found on previous inspections which indicated that not all relatives were happy that residents' health care needs were met and that they felt that they did not receive optimal care at critical illness moments in their lives.

- A report into the investigation into one such detailed concern had yet to be submitted to the Chief Inspector even though the complaint dated back to December 2018. It was not available to inspectors on this inspection on 8 and 9 May 2019

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Staff were training in this aspect of care. Care plans had been developed for residents to support staff in best-evidence based practice.

However, it was not clear to inspectors if all staff had learned from the training as an incident had occurred which allegedly had not been managed in line with policy or best evidence-based care.

The resident's plan of care had not been updated accordingly and there had be no debriefing session with staff to inform care and learning in the future.

Judgment: Compliant

Regulation 8: Protection

Inspectors remained concerned that the supervision of staff and follow-up of reported allegations of abusive interactions was not comprehensive or robust.

Inspectors discussed the need for a culture change in the organisation in relation to respecting residents' rights and wishes.

In addition, performance improvement plans for staff and safeguarding plans for residents had not been initiated. These measures would minimise the risks of repeat incidents and provided assurance to the office of the Chief inspector that there was a zero tolerance of abuse in the centre which safeguarded residents.

Some improvements had been identified in this aspect of care particularly in relation to identifying, investigating and recording alleged incidents.

Judgment: Not compliant

Regulation 9: Residents' rights

The rights of a resident who wished to wait in the hall for an appointment were not respected.

Improvements had been found as follows:

- Residents were seen to have choice in their daily routine and when inspectors arrived at the centre late in the evening of the first day of the inspection there were a number of residents still up in both sitting rooms, talking with staff and with visitors.
- Activity provision had increased and these staff were seen to be eager to provide a varied and interesting daily programme of events.
- Independent advocacy was promoted and this service was advertised in the centre for residents and their relatives.
- Staff were supported to vote and to attend religious events.
- Residents had a choice of sitting rooms and were seen to mobilise freely around the home.
- Residents were facilitated to freely access an enclosed spacious garden area which was nicely planted and furnished.
- Residents had single room accommodation with en-suite toilet facilities which promoted privacy.

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

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0027021

Date of inspection: 09/05/2019

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 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:

1) Lystoll Lodge Nursing Home are actively recruiting the position of Person in Charge. An interim Person in Charge has been appointed. The Person in Charge is a long term dedicated employee at Lystoll Lodge, who is resident centred, committed to providing the highest standard of quality care and service to residents and their family. The Person in Charge has also demonstrated their ability to motivate team working with staff. The Person in Charge has 5 years' experience working in the care of the elderly at Lystoll Lodge. Prior to commencement of the Person in Charge role, the Person in Charge was employed in a senior nurse position.

2) Throughout the recruitment process, Lystoll Lodge nursing home shall ensure the appointment, of the most competent person for the position of Person in Charge, in line with Part 3, Section 14 of the Health Act.

3) A detailed job description has been developed and approved for the role of the Person in Charge. This job description identifies the purpose, scope, duties, responsibilities and reporting relationships of the job, specifically in relation to governance and leadership, staff management, quality and safety and regulatory compliance. Completed – 03/05/2019.

4) The Person in Charge has attended Healthcare Governance and Management, Theory and Practice Training. This training incorporated a review of specific areas including, legislation, standards and guidance, roles and responsibilities, risk management, health and social care. Completed – 14/05/2019.

5) Lystoll Lodge have engaged a healthcare management specialist organisation. Support by the external organisation will be provided to the Person in Charge in a Healthcare Management support and supervision capacity. Onsite healthcare management support and supervision will allow for the review and follow up of all identified Quality

Improvement Plan's required in ensuring and maintaining Regulatory Compliance. Commenced - April 2019.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1) Induction will be completed for all new members of staff. This will be completed by the relevant Line Manager e.g.: Person in Charge or Registered Provider Representative. Commenced – 01/05/2019. 2) The Person in Charge will be responsible for the timely completion and notification of all investigations. Commenced 13/05/2019. 3) Lystoll Lodge nursing home's disciplinary policy and procedure has been communicated to team members via handover and internal multi-disciplinary care and service team meetings. The Person in Charge has responsibility for its implementation where issues of concern are identified. Completed – 21/05/2019. 4) The Person in Charge will ensure that Performance Improvement Plans are completed where required following incidents, concerns, noncompliance with Lystoll Lodge Nursing Home's policies and procedures and/or complaints received. To be completed – 28/06/2019.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1) Staff file audit to be completed. Gaps identified will be actioned immediately by the Administration staff in conjunction with the Person in Charge. To be completed – 12/06/2019. 2) Records of medication audits are managed by the Person in Charge. Completed – 13/05/2019. 3) The daily fire safety checks will be completed by the Clinical Nurse Manager or in their absence the senior nurse on duty and will be reviewed by the Person in Charge. Completed – daily. 4) Weekly review of the Directory of Residents to ensure all information as identified in Schedule 3 (b), (c) and (d) is documented. This will be completed by the Acting Person in Charge. In their absence this shall be completed by the Clinical Nurse Manager and/or the senior nurse on duty. Commenced – 10/06/2019.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: 1) Lystoll Lodge Nursing Home are actively recruiting for a Person in Charge. In the interim an acting Person in Charge has been appointed. Commenced –14/05/2019. 2) Lystoll Lodge are also actively recruiting for the appointment of a new General Manager who shall act as the Registered Provider Representative. Commenced – 21/05/2019. 3) Clearly defined governance arrangements and structures have been defined within Lystoll Lodge that set out lines of accountability of management and staff. The Registered Provider Representative role is now clearly defined in relation to oversight of support services, with the Person in Charge role directly overseeing all clinical and care aspects. Completed - 10/05/2019. 4) The reviewed and updated organisational chart is displayed in the nursing home and has been communicated to all members of staff through education and ongoing communication via handover and internal team meetings. Completed – 28/05/2019. 5) A clearly defined teams and committee structure has been developed. This includes: • Lystoll Lodge Management team; • Multi-disciplinary care team; • Multi-disciplinary service team; • Residents Committee. Terms of reference have also been developed for each of these teams which include, aims and objectives, roles and frequency. Completed – 10/05/2019. 6) A schedule for a year has been developed for all teams and committees including Management team, multi-disciplinary care team and multi-disciplinary service team. Lessons learned will be formally provided to staff through ongoing communication and scheduled team meetings. Commenced – 21/05/2019. To date the following team meeting have taken place: • Management team meeting, 21/05/2019 & 06/06/2019; • Multi-disciplinary care meeting, 21/05/2019; • Residents Committee meeting, 24/05/2019; • Multi-disciplinary service team meeting, 28/05/2019. 7) In line with the job description reviewed for the Person in Charge, a detailed job description has also been reviewed and approved for the role of the General Manager (Registered Provider Representative). This job description identifies the purpose, scope, duties, responsibilities and reporting relationships of the job, specifically in relation to governance and leadership, staff management, quality and safety and regulatory compliance. Completed - 20/05/2019.	

8) A nursing meeting was scheduled by the Person in Charge to discuss the findings from medication management audits completed to date and the findings from the draft HIQA report. This meeting included the discussion of Lystoll Lodge Nursing Home's disciplinary procedure. Completed - 27/05/2019.

9) In line with the medication management action plan, the Person in Charge will follow up with any non-compliant team members, as discussed during the team meeting. Disciplinary action will be implemented where required. To be completed – 05/07/2019

10) All identified areas for improvement addressed as part of the scheduled team meetings are appropriately actioned via Quality Improvements Plans. The Person in Charge is responsible for all areas of improvement identified as part of the multi-disciplinary care team meetings and the Registered Provider Representative responsible for all areas of improvement identified as part of the multi-service team meetings. Commenced – 21/05/2019.

11) The Person in Charge and Registered Provider Representative will ensure that Performance Improvement Plans are completed where required following incidents, concerns, noncompliance with Lystoll Lodge Nursing Home's policies and procedures and/or complaints received. To be completed – 28/06/2019.

12) All identified actions have been compiled into a Quality Improvement Plans (Actions) document, and associated timeframes and responsibilities for completion identified. This Quality Improvement Plan will be discussed at weekly management team meetings. Commenced – 21/05/2019.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
1) The Statement of Purpose has been updated to reflect the changes in relation to key management personnel and resubmitted to the Office of the Chief Inspector. Completed – 17/05/2019.

2) The updated Statement of Purpose has also been re-distributed throughout the nursing home. Completed – 17/05/2019.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1) Both the Registered Provider Representative and Person in Charge have attended "Effective Management of Complaints" training. Completed - 16/05/2019.

2) The Person in Charge has been appointed as the Designated Complaints Officer. Completed – 11/05/2019.

3) Complaints Management Process has been updated and displayed prominently in the nursing home. Completed – 11/05/2019.

4) Healthcare Governance and Management, Theory and Practice Training attended by the Person in Charge specifically addressed the management of Notifiable Events & External Reporting. Completed – 14/05/2019.

5) As part of the ongoing multi-disciplinary care and service team meetings, it has been re-enforced to staff that Lystoll Lodge aims to ensure a culture of openness and transparency that welcomes staff, residents, their family members and visitors voicing complaints, conflicts or differences of opinion in relation to the care and service provided. Commenced – 21/05/2019.

6) The Registered Provider Representative and Person in Charge are committed to ensuring all future investigations, where required are dealt with in an appropriate and timely manner to ensure that complainants and/or staff are not left in a stressful situation for extended periods of time.

7) All open investigation have been reviewed, addressed and closed off where appropriate. Action plans have been developed where investigations remain open and ongoing. Commenced – 06/05/2019.

8) Lessons learned will continue to be formally provided to staff through ongoing communication and scheduled multi-disciplinary care and service team meetings, where a complaint or issue of concern is received. Commenced – 21/05/2019.

9) The Registered Provider Representative and Person in Charge will ensure staff are supported and performance improvement plans developed and implemented where required. To be completed – 28/06/2019.

10) Additional actions completed in the management of complaints received included the development of required policies and procedures and additional documentation, specifically:

- Lystoll Lodge Internal and External Communication Policy and Procedure;
- Management of Admissions, Assessment and Care Initiation Policy and Procedure;
- Resident Individual Care Plan Development and Implementation Policy and Procedure;
- Resident Reassessment Policy and Procedure;
- Resident Discharge, Transfer and Overnight Leave Policy and Procedure.
- Resident Discharge/Transfer Form - Completed – 30/05/2019.

11) External training has also been completed on the assessment and care planning process with Chronic Obstructive Pulmonary Disease (COPD) Completed – 10/06/2019.

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies	

and procedures:
1) Policies and Procedures has been introduced as a mandatory agenda item for discussion at Management team, multi-disciplinary Care Team and multi-disciplinary service team meetings. Completed – 16/05/2019.

2) The importance of the implementation of policies and procedures has been discussed as part of the multi-disciplinary care meeting (attended by nursing staff, senior health care assistants and activities co-ordinator) and the multi-disciplinary service meeting (attended by catering, housekeeping and laundry staff). Completed – 21/05/2019 & 28/05/2019.

3) Monthly audits in relation to medication management and the prevention of elder abuse, to be completed by the Person in Charge, in order to ensure compliance with same. Commenced – 10/06/2019.

Regulation 13: End of life	Not Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
1) End of Life training is scheduled for nursing and care staff on 26th June and 17th July

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
1) An individual resident risk assessment has been completed and required controls implemented in order to reduce the risk associated with the identified residents at risk of choking. Completed – 30/05/2019.

2) All controls identified in the individual resident's choking risk assessment have also been incorporated in the corresponding residents care plan. Completed – 30/05/2019.

3) Assessment and Care plan training has been delivered to members of the nursing team on the 27th, 28th and 31st of May. This training identified the importance of ensuring all care plans are updated based on the risks identified following assessment and in ensuring Health and Social Care Professionals recommendations are also incorporated. Additional assessment and care plan training to be scheduled to ensure all members of the nursing team receive the required assessment and care plan training. To be completed 05/07/2019.

4) Appropriate storage of first aid kit and suction machine has been identified. Completed – 14/05/2019.

5) Agency staff orientation programme also updated to ensure awareness of access to first aid kit and suction machine. Completed – 21/05/2019.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1) Fire safety requirements identified have been completed and fire safety compliance plan submitted to HIQA. Completed – 20/05/2019.

Examples of work completed includes:
• Fire risk assessment;
• Upgrade of fire detection system;
• Smoke detectors installed in attic;
• Upgrade works on emergency lighting;
• Fire and smoke seal replacement;
• Completion of fire drills

2) The daily fire safety checks will be completed by the Clinical Nurse Manager or in their absence the senior nurse on duty and will be reviewed by the Person in Charge. Completed – daily.

3) Night simulated fire drills were completed week commencing 27/05/2019. These drills were completed specifically for members of staff working during the night.

4) Mandatory fire training has been completed for all new staff members. Completed 03/05/2019.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1) Medication Management action plan has been developed and rolled out. Completed – 13/05/2019.

2) Process mapping sessions have been completed in relation to Prescribing, Ordering, Storage and Disposal of Medication and Administration Medication. Completed - 15/05/2019.

3) Flow charts have been developed in relation to prescribing, ordering, storage and disposal of medication and administration of medications – these are clearly displayed in the nurse's station. Completed - 16/05/2019

4) Education has been provided by the Acting Person in Charge and external specialist organisation. This has been provided both individually to members of the nursing team and re-enforced during the nursing team meeting. Completed - 20/05/2019.

5) Ongoing weekly spot checks audits as per action plan will continue to ensure full compliance with Regulation 29. This has shown an improvement in drug administration

errors Commenced – 16/05/2019.

6) Nursing meeting was attended by 7 of 9 members of the nursing team and was chaired by the Person in Charge with the support from external organisation. This meeting addresses all medication issues identified to date and identified as part of the HIQA draft inspection report. Completed - 27/05/2019.

Agenda items included:
• Medication Management Processes
o Prescribing;
o Ordering;
o Stock and Restock.
• Medication Management Audit Results.

7) Person in Charge will schedule follow-up meetings with individual nursing team members, where required. To be completed - 27/06/2019.

8) Medication competency assessments to be completed for individual members of the nursing team. To be completed – 28/06/2019.

9) The Person in Charge is responsible for the review and development of the staff roster. The Person in Charge is always committed to ensuring appropriate staffing levels and the appropriate allocation of the nursing team based on experience. Commenced – 20/05/2019.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1) Assessment and Care plan training has been delivered to members of the nursing team on the 27th, 28th and 31st of May 2019. Evidence of this is maintained in their staff file

This training discussed in detail the Care Planning Cycle, including:
• Assessment;
• Diagnosis;
• Planning;
• Implementation, and;
• Evaluation.

Completed – 31/05/2019.

2) Additional assessment and care plan training will be provided to members of the nursing team. To be completed – 05/07/2019.

3) A full review of all resident's care plans is currently being undertaken in the nursing home. These reviews are being completed by the allocated nursing team member, to

ensure that care plan entries reflect each identified individual resident specific need. To be completed - 28/06/2019.

4) Monthly sample care plan audits to be completed and feedback provided to the nursing staff where issues are identified.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1) Ongoing communication with individual GPs occurring. Person in Charge will oversee that all resident Kardex's are in date and reviewed by GP. To be completed – 08/07/2019.

2) Both the Registered Provider Representative and Person in Charge have attended "Effective Management of Complaints" training. Completed - 16/05/2019.

3) The report into the investigation discussed has been submitted to the Office of the Chief Inspector. An in-detail action plan has been developed. Actions completed to date, include:

• Specific assessment and care plan training provided.
• Education to care staff in relation to the accessing and involvement in residents care plans and care planning process.
• Additional COPD external training completed – 10/06/2019.
• Additional policies and procedures processed mapped, developed and approved.
• Accompanying documentation including discharge/transfer letter developed and implemented. Completed – 31/05/2019.

4) Additional training to members of the nursing team and care staff will be completed in relation to the assessment and care planning process. To be completed – 05/07/2019.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1) Safeguarding training completed – 26/04/2019.

2) Investigations have commenced and notifications submitted to HIQA. Preliminary investigations completed and managed in line with Lystoll Lodge Nursing Home's elder abuse and disciplinary policy and procedure. Completed – 24/05/2019.

3) Safeguarding plans have been developed and implemented. The Person in Charge will ensure that these are developed and reviewed for effectiveness as and when required in order to minimise the risk of repeat. Completed – 24/05/2019.

4) In line with safeguarding plans for residents, performance improvement plans for staff where identified as required will be completed by the Person in Charge in conjunction with the staff member.

5) Ongoing support and supervision is provided by the Person in Charge directly to all clinical and care staff. Respecting residents' rights and wishes is discussed daily as part of the handover process. Completed – 21/05/2019.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1) Recognising, protecting and promoting the rights and diversity of residents, and their family members, is a fundamental part of the care provided at Lystoll Lodge Nursing Home. Lystoll Lodge is committed to ensuring that each individual resident right is respected. The importance of respecting each individual residents' rights is communicated to all members of the team via handover meetings, one to one discussion where required and scheduled internal team meetings. Completed 28/05/2019.

2) Care plan reviews will include specifically the incorporation of individuals residents wishes and preferences. To be completed - 05/07/2019.

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.	Substantially Compliant	Yellow	19/07/2019
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	Substantially Compliant	Yellow	19/07/2019

	and suitable facilities are provided for such persons.			
Regulation 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Red	17/05/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	12/07/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	28/06/2019
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Not Compliant	Orange	28/06/2019
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 Inspector.	Substantially Compliant	Yellow	12/06/2019
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	Not Compliant	Orange	17/05/2019

	all areas of care provision.			
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	17/05/2019
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		30/05/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	10/06/2019
Regulation 28(2)(iii)	The registered provider shall make adequate arrangements for calling the fire service.	Substantially Compliant	Yellow	10/06/2019
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	Not Compliant	Orange	28/06/2019

	any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	17/05/2019
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.	Substantially Compliant	Yellow	19/07/2019
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.	Not Compliant	Yellow	19/07/2019
Regulation 04(1)	The registered provider shall prepare in writing, adopt and	Substantially Compliant	Yellow	28/06/2019

	implement policies and procedures on the matters set out in Schedule 5.			
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).	Substantially Compliant	Yellow	05/07/2019
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.	Substantially Compliant	Yellow	05/07/2019
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	Not Compliant	Orange	05/07/2019

	Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(b)	The person in 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.	Not Compliant	Orange	12/07/2019
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	28/06/2019
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	28/06/2019
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.	Substantially Compliant	Yellow	05/07/2019
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to	Substantially Compliant		14/06/2019

	independent advocacy services.			