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:	14 January 2020
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0028011

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:	45

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
Tuesday 14 January 2020	11:00hrs to 18:40hrs	Mary O'Mahony	Lead
Wednesday 15 January 2020	09:00hrs to 18:00hrs	Mary O'Mahony	Lead
Tuesday 14 January 2020	11:00hrs to 18:40hrs	John Greaney	Support
Wednesday 15 January 2020	09:00hrs to 18:00hrs	John Greaney	Support

What residents told us and what inspectors observed

Inspectors spoke with the majority of residents over the two days of inspection. They said that they were content in the centre and that staff were kind to them. A number of relatives were also spoken with and they were complimentary of the new management team and said they were confident that issues of concern would be addressed.

Mealtimes were generally communal events in the spacious dining room. Residents said that choices were offered and that the quality of the food was very good. Where they had expressed any dissatisfaction this was resolved without delay.

Residents said that the range of activities had improved and they said that they particularly enjoyed the music, card games, visits from pet therapy and the Christmas celebrations.

Residents' meetings were held. The minutes of these meetings were seen to be recorded and were available to inspectors. Residents also said that the person in charge and the RPR met with them on a individual basis. They informed inspectors that they had no concerns about approaching the senior management team if they were worried about something.

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

A small number of residents who raised concerns with inspectors were assured that these issues would be passed on to the person in charge for resolution.

Capacity and capability

This unannounced inspection of Lystoll Lodge Nursing Home took place to evaluate the impact and sustainability of the new governance and management structure on the two dimensions of care inspected against in the report, namely: Capacity and Capability and Quality and Safety of Care. The centre had established a record of repeat non compliance with Regulations and inadequate provider responses to actions from previous inspections. As a consequence the Chief Inspector had issued a notice of proposed decision to cancel the registration 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. The previous unannounced inspection of 2 and 3 October 2019 had demonstrated that the provider had instigated a number of improvement initiatives in the

centre. Following that inspection the office of the chief inspector decided to allow the registered provider further time for these changes to be fully implemented.

On this inspection while inspectors found that there were still a number of non-compliances in relation to Regulations it was apparent that the new person in charge and the new registered provider representative(RPR) had put robust systems in place to support and supervise staff, to manage complaints and to monitor, identify and address poor practice. These improvements were acknowledged by inspectors.

The new RPR and the new person in charge had diverse and extensive experience both in older adult nursing and social care management. This experience meant that they had the capability and skill to establish a safe model of care which combined social and medical care for residents in the centre. At the feedback meeting with the RPR and the person in charge, following this inspection, improvements were acknowledged and the areas of non compliance were highlighted.

Improvements in relation to Governance and Management arrangements were detailed under Regulation 23 in this report.

In summary:

- the new management team were found to be enthusiastic and driven in their quest to ensure the provision of a service for residents that was safe, appropriate, consistent and effectively monitored
- they had taken comprehensive steps to achieve compliance and were engaged in a process which included training nurse managers in supporting the necessary culture change to achieve this aim
- 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 from inspectors' review of documentation in relation to fire drills and fire safety certification.

Nevertheless there were issues to be addressed as follows:

- maintaining a correct roster
- staff files to be completed in line with the requirements of Schedule 2 of the Regulations
- providing mandatory and appropriate staff training for all staff
- culture change to be established and maintained

The registered provider representative was required to submit:

- a timely, comprehensive and achievable compliance plan based on the findings of this inspection.
- evidence that the required outstanding fire safety plans were made available to the centre
- retrospective notifications for the concerns identified on inspection

Most of the records and documentation as required by Schedule 2, 3 and 4 of the Regulations were available in the centre. Staff files required further attention

however. The documents which were not available to inspectors were outlined in more detail under Regulation 21 in this report.

In conclusion, the findings of this inspection were that the centre was on a defined pathway to improvement. However, continuous improvement, supervision and oversight was required on the part of the provider of Lystoll Lodge Nursing Home to ensure full regulatory compliance with Standards and Regulations for the sector, which set out the requirements for the management of a designated centre and the rights, care and welfare of residents.

Regulation 14: Persons in charge

The person in charge fulfilled the requirements set out in the Regulations for the sector. She was experienced and knowledgeable. She understood her remit and the responsibilities of her role.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were appropriate for the needs of residents and there was a nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix was seen. Training was provided by internal and external trainers. The majority of staff had been afforded appropriate training for their roles and responsibilities. They were supervised in their respective roles and were made aware of the regulations and standards by the person in charge. Staff appraisals were underway and supports were provided where improvements were required. Nevertheless, inspectors found that not all performance improvement plans (PIPs) contained sufficient detail to assure inspectors that there were clear targets set out by which performance improvement could be measured.

However, inspectors acknowledged the fact that this was a new initiative since the previous inspection. Inspectors were assured by the person in charge that the current documentation would be enhanced to set out a clear pathway and time line for improvement and maintain records of related supervision meetings.

A number of staff were yet to receive mandatory training in safeguarding residents and preventing elder abuse. This included a number of new staff members whom inspectors saw had been scheduled for upcoming training. The person in charge stated that all staff had an introduction to the subject of abuse prevention in their induction programme. This was confirmed by staff spoken with by inspectors. Documentation relating to the induction programme was reviewed.

Inspectors found that 11 staff had yet to attend training in supporting the behaviour and psychological symptoms of dementia (BPSD). This included the cohort of new staff members. However, this training course had been developed in-house since the last inspection. It included project work and the detailed, experiential programme was scheduled to be delivered to all staff in rotation.

Judgment: Not compliant

Regulation 21: Records

All the regulatory records were not available to inspectors:

For example:

- in one staff file there was no photographic identification or personal identification number (PIN) available for one nurse. This was provided during the inspection
- not all references were independently verified and not all files contained references from the previous employer
- there were gaps in the curriculum vitae (CVs) of a number of files in the sample reviewed by inspectors.

On the morning of inspection the staff roster incorrectly stated that the senior management team were on duty when inspectors arrived at the centre. Inspectors were informed that one of these staff members was on study leave and one staff member was at meetings. However, both staff members made themselves available to inspectors in the centre during the two days of inspection.

Management staff explained to inspectors that the correct maintenance of staff files was impacted on by the fact that there had been no administration support for the previous two months.

This situation had now improved and there was a plan in place to employ an additional staff member in the near future to attend to administration and reception duties.

Judgment: Not compliant

Regulation 23: Governance and management

There was a robust governance and management system in place which included:

- regular staff meetings
- a programme of staff supervision and performance improvement
- a system of audits
- trending of complaints and falls.

The management team included two clinical nurse managers (CNMs) who reported that they had recently been granted one dedicated day a week to attend to administration duties which included auditing, supervising care plan updates and medication management.

The risk register was updated weekly, all staff had the required Garda vetting (GV) clearance in place and policies and procedures were reviewed on a three yearly basis or as required.

A programme of training was ongoing to include training in recognising the signs of clinical deterioration in residents. This training was required in response to a previous incident and resultant complaint in the centre.

Management staff had supported the extension of a more challenging and interesting activity programme to include Sonas (activating the potential for communication) for residents with dementia.

There remained issues to be addressed as follows:

- maintaining a correct roster,
  staff files to be completed in line with the requirements of Schedule 2 of the Regulations,
  providing mandatory and appropriate staff training for all staff,
  culture change to be established and maintained.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Contacts for residents included the costs of services and the number of the bedroom which had been assigned to residents on admission.

Judgment: Compliant

Regulation 3: Statement of purpose

This document contained all the regulatory requirements including details on residents' rights and the medical and social services on offer in the centre.

Judgment: Compliant

Regulation 30: Volunteers

A number of volunteers provided invaluable support to residents in relation to music, community support, community news and spiritual care. For example, volunteers came to the centre with communion at weekends and pet therapy volunteers visited with pet dogs and cats.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents had been notified as required:

For example:

Incidents where falls had resulted in hospitalisation for two residents and an incident where a vulnerable resident was found outside the building before being returned by staff.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were recorded.

Inspectors found that details as to the satisfaction of the complainant had not been documented on all records.

However, it was apparent to inspectors that documentation had improved over the previous three months as the new management team became involved in the process.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

All policies and procedures were in place and up to date.

Judgment: Compliant

Quality and safety

Findings on this inspection were that the quality and safety of care was now supported by a more robust and consistent management approach.
This included increased supervision and effective delegation which assigned responsibilities to relevant staff members. This meant that residents' lives and well being were improved and enhanced. Staff nurses were now maintaining a presence upstairs, which was a key component in establishing staff and resident supervision for the cohort of residents there. In relation to the provision of meaningful activities inspectors found that activity staff members were very enthusiastic in regards to providing activities such as art, knitting, card games, Sonas and music. Activity staff also spoke with inspectors about gathering information on residents' interests and previous hobbies to inform the daily programme.

On this inspection, inspectors found that care plan documentation was detailed and it was subject to peer audit. Staff had been re-trained in care planning and documentation since the previous inspection. A sample of care plans was reviewed and it was apparent to inspectors that the majority of staff had integrated the learning into their work. Details of care planning and issues to be addressed were highlighted under Regulation 5: Care Planning, in this report.

Inspectors found that while there was a programme of training in place a number of staff had yet to attend a training course, which was necessary following a previous concern in relation to end-of-life care. This was a repeat finding. This issue was detailed under Regulation 16: Staff Training and Development. The governance team spoke with inspectors about the challenges of encouraging and training some members of staff who who had yet to embrace the new culture of care where all residents' voices matter, where residents and staff were encouraged to speak with inspectors and where staff communicate respectfully with residents at each interaction and care-giving procedure. Inspectors found that the governance team had a very good relationship with each other and a clear vision as to how to achieve this care ethos.

In relation to medicine management, increased supervision, adequate training and comprehensive on-going audit had led to improved practice. This reduced the

risk presented to residents' by poor practice and incorrect records. These measures were put in place following findings on previous inspections. Robust processes had been required to ensure the safety of residents and correct professional practice.

Infection control had been maintained. Issues such as hand-washing and the use of personal, protective equipment (PPE) was observed by inspectors and staff were found to be aware of infection control best practice. This aspect of risk was discussed under Regulation 27: Infection control.

Safeguarding of residents was supported by training and appropriate policies on the prevention, detection and response to abuse. Nevertheless, inspectors were made aware of an issue of concern related to resident care which had been detailed under Regulation 8: Protection, in this report.

Fire precautions had previously been reviewed by a specialist inspector of estates and fire safety from the office of the Chief Inspector and a number of areas for improvement had been highlighted. On this inspection inspectors found that the registered provider had taken measures to significantly improve the level of fire safety, both in terms of the building upgrade and staff practices. Inspectors found that significant progress had been made in relation to addressing fire safety deficits which were found on 3 April 2019 . Engagement between the RPR and the office of the Chief Inspector was ongoing in this regard. Findings from this inspection were highlighted under Regulation 28 in this report. The name of the person who would take charge during a fire was displayed on the staff notice board for each shift and identified on the staff rota. Documentation was made available to inspectors which provided the required assurances that the fire rated ceiling throughout the first floor created an effective barrier to the spread of fire and smoke.

Overall the quality and safety of care required continuing action and robust supervision to achieve compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The new governance and management arrangements were having a positive impact on regulatory compliance which was necessary to safeguard residents and promote a positive impact on the quality of life and safety of residents living there.

Regulation 11: Visits

Visitors were plentiful throughout the two days of inspection. Residents were happy to see them and they spoke with inspectors. They were seen to be familiar and happy with staff members.

Judgment: Compliant

Regulation 12: Personal possessions

Residents expressed satisfaction with their accommodation. They had sufficient space to store personal item. Pictures, photographs of family and personal items of value were displayed in their rooms.

Judgment: Compliant

Regulation 13: End of life

Training had yet to be rolled out in this aspect of care which was highlighted under Regulation 16: Staff training and development in this report.

The need for this training was highlighted by inspectors as alleged end-of-life care deficits were the subject of a previous complaint which was still open in the centre.

Judgment: Compliant

Regulation 17: Premises

The premises was brightly painted and the decor was comfortable and suitable for residents. There was adequate communal accommodation in the upstairs and on the ground floor level.

In all there were only six shared showers available for residents' use. Of these, one shower room was located in the reception area and was rarely used due to privacy and dignity implications, according to staff. Another bathroom and shower area was seen to be used as a laundry storage room. This meant that only four showers were in use for 48 residents on most days. This limited availability and choice for residents particularly as the bath was not always accessible due to the items stored in this bathroom/shower room.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The dining room was located to the front of the building and provided views over the surrounding countryside.

The kitchen was adjacent to the dining room which meant that kitchen staff could check residents' satisfaction with meals and provide alternatives if necessary. Staff

were appropriately trained and the chef was trained and knowledgeable of residents dietary needs and preferences. The dietitian had provided information and training to kitchen staff on modified and special dietary requirements.

Home baking was provided and residents expressed satisfaction with the choices on offer.

Judgment: Compliant

Regulation 20: Information for residents

Residents had been made aware of management changes through residents' meetings.

Advocacy was available if requested.

Community involvement meant that residents were aware of all the local news and items of interest.

A resident's guide was available to all residents. This set out the arrangements in place for medical and allied health care as well as advising residents of their rights to complain, to speak with advocates and have full access to relatives and visitors.

Judgment: Compliant

Regulation 26: Risk management

The risk register was maintained and updated regularly. The policy contained the details required under Regulation 26.

Judgment: Compliant

Regulation 27: Infection control

Staff were trained in infection control and particularly in hand washing techniques.

However, inspectors found that there was a very soiled cushion in the oratory, which was removed for cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A number of concerns in relation to fire safety systems and practices, which had been highlighted during the previous inspections had been addressed.

All staff had attended fire safety training.

Fire drills were carried out on a regular basis and documentation was seen to this effect.

Fire safety equipment was serviced and quarterly checks of the fire alarm and emergency lighting had been carried out according to documentation seen.

Documentation was available to provide assurance that the fire safety system in the centre complied with best evidence practice and the standards for the sector. This included a letter of assurance that the first floor ceiling area provided an effective barrier to the spread of fire and smoke.

Outstanding issues to be addressed included:

- Moving a number of empty under-stair cupboards on escape corridors which were not enclosed in fire rated construction.
- Suitable maps in the form of zoned floor plans were not yet available adjacent to the fire panel to assist staff in identifying the location of fire in the event of the fire alarm activating.

The RPR stated that these maps had been promised before Christmas but they had not been delivered to date.

The RPR was asked to follow up on any outstanding issues with the specialist inspector in fire and estates at the office of The Chief Inspector, who had previously inspected the centre in relation to fire safety management.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Staff training was undertaken by all staff. Documentation was well maintained in relation to the recording of controlled drugs, which were held in the centre.

The documents were made available to inspectors on this inspection.

The correct maintenance of these documents had been subject to comprehensive audit and supervision by the person in charge. Consequently there had been a noted

improvement and they were now written up in line with the protocols set out in the guidance document for nurses, issued by An Bord Altranais.

Signatures were now seen to be entered following administration of medicines, in line with best practice.

Medicine errors were recorded and it was clear that learning was disseminated to all staff from audit.

Staff who did not follow correct protocol were followed up through supervision plans and peer support.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans were now assigned to individual nursing staff. They were generally updated within the required, regulatory four-monthly time frame.

Pre-admission assessment documentation was filled out prior to admission to ascertain if residents' needs could be met within the centre.

Audit of care plans was seen to be ongoing on a weekly basis and each care plan was discussed with the staff member involved following the audit.

During the inspection inspectors reviewed a sample of care plans and found that:

- one care plan had been inaccurately updated when inspectors arrived in the centre: this related to the cognitive ability of a resident
- a personal evacuation plan required updating
- the resuscitation status of one resident had not been updated since the resident changed her advanced care wishes.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to allied health services including the dietitian, the speech and language therapist (SALT), dentist, optician and chiropody.

Specialist palliative services, pharmacists, hospital visits, consultants and GPs (general practitioners) were accessible to residents.

Documentation was seen, in a sample of care plans, confirming that referrals had

been sent and that access had been facilitated through visits where appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

As discussed under Regulation 16: Training and staff development, training in this aspect of care had been made available to the majority of staff. A schedule and plan was seen to be in place to provide all staff with a bespoke training session on positive behaviour support, relating to their work with residents within the centre. Residents who were inappropriately placed were moved to another centre following consultation with residents and relatives.

Judgment: Compliant

Regulation 8: Protection

Residents said that they felt safe in the centre. A number of them spoke with inspectors about the kindness of staff and how staff supported them in their daily lives. A small group of staff were awaiting relevant training which was highlighted under Regulation 16: Training and staff development.

A resident spoke to inspectors about an alleged interaction which caused distress. These concerns were shared with the person in charge who was required to submit a retrospective relevant notification, as required by the Regulations.

The RPR and the person in charge were not aware of the alleged inappropriate interaction and stated that they would follow up on the information provided to inspectors.

The centre acted as a pension agent for three residents and these accounts were held separately from the centre's main bank account.

Receipts and invoices were available to all residents where necessary.

Judgment: Not compliant

Regulation 9: Residents' rights

There were facilities in the centre for occupation and recreation in accordance with their interests, capacity and capability. There was a very enthusiastic activities

coordinator for residents. She spoke with inspectors and presented as person-centred, respectful, knowledgeable and kind.

The activity programme had been enhanced and some members of the care staff supported the coordinator in rolling out the programme at weekends and in the sitting rooms during the day. Senior care assistants supported her in delivering the programme which was available to residents. Staff and residents spoke with inspectors about the daily programme and were seen to be familiar with the events. Residents spoke about outings and the wonderful Christmas celebrations.

Restraints, such as bed rail use, was supported by policy and detailed documentation on assessing risk and benefits.

Residents' spiritual needs were met and they said that they could go out to vote externally or be facilitated to vote in the centre.

While activity equipment and items of interest were available to staff at weekend,s in order to provide weekend activity, there was no specific person assigned to carry out the activity. This meant that there was a risk that residents were not afforded access to social events at weekends.

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	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially 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	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	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-0028011

Date of inspection: 15/01/2020

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We will ensure all mandatory training is up to date and a plan in place for future training. We will ensure all performance improvement plans (PIPs) will contain sufficient detail to ensure that there are clear targets set out ,by which performance improvement can be measured. All documentation will be enhanced to set out a clear pathway and time line for improvement and records of supervision meetings will be maintained. Training has now been scheduled for the 11 staff that were yet to attend training in supporting the behaviour and psychological symptoms of dementia (BPSD).	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: We will ensure all storage of records are secure and staff files contain all documentation in schedule 2. We will ensure all files contain photographic identification or personal identification number (PIN) if applicable. We will ensure all references are independently verified and all files contain references from the previous employer We will ensure all gaps are explained in the curriculum vitae (CVs) . An additional staff member has now been employed to assist with all the admin and reception duties.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We will ensure the quality and safety of care delivered to our residents is monitored on an ongoing basis, by having regular quality meetings, raising corrective actions to drive improvement and consultation with our residents. We will ensure that we maintain a correct roster and that all staff files are completed in line with the requirements of Schedule 2 of the Regulations.We will also ensure that we provide all mandatory training for all staff.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
We will ensure a record of all incidents that occur is maintained and where required notified .We will ensure all relevant details of each incident are recorded with actions taken and all are analysed for learning purposes.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
We will ensure complaints are logged in the complaints book and ensure the outcome of the complaint is recorded , if complaints regarding the services are made through the residents meeting we will ensure these are addressed at the Quality Meeting.
We will ensure that the satisfaction of the complainant is documented on all records.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: We will ensure all areas in the Home meet the privacy, dignity and wellbeing of each resident. We will ensure the showers are all available for residents' use. We will also ensure the bath is accessible for residents.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: We will ensure that procedures, consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority are implemented by staff.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The empty under-stair cupboards on the escape corridors which were not enclosed in fire rated construction are scheduled to be removed on 25.02.2020 Suitable maps in the form of zoned floor plans are ordered and will be adjacent to the fire panel to assist staff in identifying the location of fire in the event of the fire alarm activating.	
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: We will ensure each resident has a care plan, based on an on-going comprehensive assessment of their needs which is implemented, evaluated and reviewed, reflects their changing needs and outlines the support required to to maximise their quality of life in accordance with their wishes. We will ensure all care plans are accurately updated.	

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: We will ensure each resident is safeguarded from abuse and neglect and their safety and welfare is promoted. We will ensure all staff have relevant training The issue of alleged inappropriate interaction has been adressed through the relevant policies and procedures.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: We will ensure the rights and diversity of each resident are respected and safeguarded. Each resident is offered a choice of appropriate recreational and stimulating activities to meet their needs and preferences A staff member will be identified on the allocation list each weekend to ensure residents have access to activities of their choice	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Yellow	30/04/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Yellow	25/02/2020
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	Yellow	25/02/2020
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation	Substantially Compliant	Yellow	30/06/2020

	3.			
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	30/06/2020
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.	Not Compliant	Yellow	30/03/2020
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by	Substantially Compliant	Yellow	25/02/2020

	staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/03/2020
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	30/03/2020
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	25/02/2020
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	25/02/2020

Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints 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.	Substantially Compliant	Yellow	25/02/2020
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.	Substantially Compliant	Yellow	25/02/2020
Regulation 34(2)	The registered provider shall 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	Substantially Compliant		25/02/2020

	and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
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	25/02/2020
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant		25/02/2020
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant		25/02/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	25/02/2020
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has	Substantially Compliant		25/02/2020

	access to independent advocacy services.			