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 Limited
Address of centre:	Skehenerin, Listowel, Kerry
Type of inspection:	Unannounced
Date of inspection:	01 September 2021
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0032528

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 48, 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:	40

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
Wednesday 1 September 2021	08:40hrs to 18:00hrs	Ella Ferriter	Lead
Wednesday 1 September 2021	08:40hrs to 18:00hrs	Mary O'Mahony	Support

What residents told us and what inspectors observed

The inspectors met and spoke with several residents during the inspection of Lystoll Lodge Nursing Home. Overall, the feedback from residents was that staff were caring and kind towards them, and they were very happy living in the centre. The inspectors arrived to the centre unannounced, on the morning of the inspection. They were met by the administrator, who ensured that all necessary infection prevention and control measures, including hand hygiene and temperature check were implemented, prior to entering the centre.

Following an opening meeting with a Clinical Nurse Manager, the inspectors were guided on a tour of the premises. Lystoll Lodge Nursing Home is two story designated centre, on the outskirts of Listowel town. It is set on well maintained grounds, with a nice garden to the front of the premises. The centre is registered to provide care for 48 residents, and there were 40 residents living in the centre on the day of this inspection. The centre is divided into four wings: a West and East wing on each floor. New signage to identify these areas, had been installed since the previous inspection. Residents bedroom accommodation consists of 28 single rooms and 10 twin rooms. Each bedroom has a bathroom, which comprises of a toilet and sink. Access to showers for residents are available on each corridor. There was adequate space in residents' bedrooms to store their personal possessions and clothing. Residents were facilitated to personalise their bedrooms with memorabilia and photographs. There was open safe access to the centre's secure garden, which was paved, and had nice seating. Residents told inspectors they enjoyed meeting their families out here during the nice weather, and praised staff for welcoming their families and serving them tea and snacks.

Overall, the premises appeared clean and there were adequate housekeeping staff rostered each day. However, the inspectors noted that some areas of the premises required review, such as painting and replacement of equipment, which is discussed further under regulation 17. Staff had completed relevant training in infection prevention and control and were observed to consistently adhere to hand hygiene and appropriate infection prevention and control precautions. Housekeeping staff were clear about the enhanced cleaning processes that were required during the pandemic and demonstrated a good knowledge of infection prevention and control practices relevant to their work. Residents in isolation were situated in a designated part of the centre, and there were robust infection and control procedures implemented.

The inspectors observed interactions between the staff and residents throughout the day and found that they were warm, empathetic and respectful. The inspectors spoke to a number of residents informally throughout the inspection and spoke to approximately ten residents in more detail, to gain a better insight of their lived experience in the centre. Overall, residents reported a good quality of life in a homely environment, and they were complimentary about the care in the centre. Residents spoke about the difficulty and challenges that the last year brought, as

they had limited access to their families, and their movements were restricted due to the global pandemic. Residents assured the inspectors that they were always kept informed regarding restrictions and COVID-19. Residents expressed their relief that they had not experienced COVID-19 in the centre, and praised the staff for "keeping them going and entertained".

Staff spoken with told the inspectors they enjoyed working in the centre, and it was evident they knew residents well. They informed inspectors that they had received additional training recently, in areas such as falls prevention, end of life care and nutrition, which they found very beneficial for their role. A review of the rosters by the inspectors and observations on the day of this inspection, evidenced that there were insufficient numbers of care staff rostered in the morning, when considering the care needs of residents and the size and layout of the centre. This resulted in residents being delayed with morning care and residents lunches being delayed upstairs. The inspectors acknowledged that there was an unexpected absence of one healthcare attendant on the day of this inspection. The impact of caring for two residents in isolation, and additional time required, had also not been considered when rostering staff.

The inspectors observed residents' daily lives throughout the day of the inspection, in order to gain insight into the experience of those living there. Some residents spent their day in the sitting rooms, both upstairs and on the ground floor. There were three communal rooms on the ground floor, two sitting rooms and a dining room. In one sitting room there was a lack of adequate supervision of residents, most of whom had high dependency needs. Inspectors observed residents calling for staff on a few occasions throughout the day, and they were not always responded to in a timely manner.

The sitting room on the first floor was a hive of activity and residents were observed taking part in numerous activities throughout the day. Daily and weekly newspapers were delivered to residents, which they reported they looked forward to. Residents interacted very well with staff, and were observed laughing and joking during the day. The activities programme displayed was rich and varied and it included quiz's, physical exercises, bingo, games, Mass and the Rosary. Before lunch the activities coordinator had a reminiscence session with residents, where they recalled their school days. However, there was no activity provision evident on the ground floor on the day of this inspection. The inspectors were informed that the centre had a second activities coordinator, however, this person had ceased employment the week prior to this inspection. A monthly newsletter was issued in respect of activities and life in the designated centre, which was shared with residents and families.

Residents spoke positively about the food provided in the centre, particularly the home baking. A review of records evidenced that where residents gave feedback regarding food, it was actioned. The inspectors observed lunch in the main dining room downstairs. There was a choice of main meal and dessert, and residents were pleased with the food quality and choice. Although there was an easing of restrictions and residents could use the dining room freely, only four residents were seen to eat in the dining room. Residents that lived on the first floor were observed eating in the sitting room or their bedroom, which was their personal choice. The

person in charge informed the inspectors that the centre was currently reviewing the dining experience for residents, and they always ensured residents had choice with regards where they would like to have their meals.

Visiting to the centre had resumed, was being monitored, and visitors were appropriately screened before entering the centre. The inspectors spoke with two visitors that had pre-scheduled appointments. Feedback was overwhelming positive and they stated that their relative was well cared for and they praised the kindness and approachability of staff. Visitors told the inspector that the last year, and the pandemic, had been very difficult and they were delighted to come back visiting again and seeing their loved ones in person.

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

Capacity and capability

This was a one day unannounced risk inspection to monitor compliance with regulations. Lystoll Lodge Nursing Home had a poor history of regulatory compliance, and the findings of the inspection evidenced that the standards of care had improved, in several of the regulations inspected. Non-compliance's identified on previous inspections had been predominantly addressed, in areas such as staff training and infection control. There was also evidence of improvements in the overall governance and management of the centre since the previous inspections, of October 2020 and January 2021. A number of systems had been put in place to ensure that the service provided is safe, appropriate, effective and consistently monitored. However, these systems were at an early stage of implementation and continued commitment was required by the registered provider to sustain these improvements, and to ensure a quality service for residents was delivered. The main finding on this inspection was that staffing levels required review to ensure they were appropriate to meet the assessed needs of residents. Some further improvements were also required in relation to maintenance of the premises, infection prevention and control, care planning and fire precautions.

The registered provider of this centre is Lystoll Lodge Nursing Home Limited, which comprises of three directors. There was a defined management structure in place, and the lines of authority and accountability were clear. One director worked full time in the centre as the general manager, and was actively engaged in daily operations. A new person in charge had been appointed, since the previous inspection, however, they did not meet all the regulatory requirements, which is detailed under regulation 14. Care in the centre is directed through the person in charge, who reports to the general manager. From a clinical perspective the person in charge is supported by two Clinical Nurse Managers, and a team of nurses, healthcare assistants, catering, household, activities and administrative staff. There

were effective deputising arrangements to ensure management cover was available at all times, including the weekends.

There were appropriate supervision arrangements in place for staff and staff were supported in carrying out their duties. However, the staffing number and skill mix on the day of inspection was found to be insufficient, to ensure the effective delivery of care, in accordance with the centres statement of purpose. This is further detailed under regulation 15. Improvements were noted in the provision of staff training and maintenance of training records, some staff were awaiting training in one mandatory area, which was booked for the following month. Records of staff meetings evidenced consultation with all staff disciplines, and staff feedback was actively sought for the adoption and implementation of improvements within the centre. This included risks identified in the centre, reviews of audit findings and initiation of quality improvement projects, such as a falls prevention strategy and enhanced training in end of life care and nutrition.

All records as requested during the inspection were made readily available to the inspectors. Records were maintained in a neat and orderly manner and stored securely. However, on review of a sample of staff files it was found that not all complied with the regulatory requirements, which is discussed under regulation 21. Accidents and incidents were recorded, appropriate action was taken, and they were followed up on and reviewed by management. Complaints were recorded and investigated in line with the regulation, and the centres complaints policy.

Management systems were effectively monitoring quality and safety in the centre. Weekly key performance indicators were collected on falls, restraint, medications and weight loss, and these were discussed and reviewed at weekly management meetings. All incidents had been notified to the Chief Inspector, as per requirements of the legislation. In summary, this inspection found improvements had been implemented since the previous inspection and the provider has displayed a commitment to achieving regulatory compliance.

Regulation 14: Persons in charge

There was a new person in charge recently appointed, in July 2021. They had the necessary experience in management and in nursing the older adult. However, they did not hold a management qualification, which is required by the regulation. The inspectors were informed that the course was currently being undertaken and was due for completion in November 2021.

Judgment: Not compliant

Regulation 15: Staffing

On the day of the inspection, there were 40 residents accommodated in the centre. Of these, 25 has been assessed as having high to maximum dependency levels and 15 medium/ low dependency levels. A review of the staffing levels on the day of the inspection found that staffing was not adequate to meet the assessed needs of the residents, when also considering the size and layout of the building. The effects of this deficit in staffing resulted in:

- breakfast being observed to be left on trays beside residents, where residents required assistance.
- personal care delivery being delayed, as some residents had to wait to get assistance until 12 midday.
- lack of activities on the ground floor.
- dinner meals being delayed for residents on the first floor.
- supervision arrangements were inadequate in one sitting room, where residents with high needs were observed requiring assistance, which was delayed.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of the training records for staff found that there was a gap in mandatory staff training for 20 percent of staff, pertaining to managing responsive behaviors. This was scheduled in the coming weeks.

Judgment: Substantially compliant

Regulation 21: Records

A sample of five staff files were reviewed by the inspectors. They did not all comply with the requirements of Schedule 2 of the regulations. In particular:

- Three files had gaps in Curriculum Vitae.
- One file did not have two references.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improved management systems had been implemented and required ongoing

development and review, to ensure that the service provided is safe, appropriate, consistent and effectively monitored. Further improvements were required in the following areas:

- ensuring staffing levels and skill mix of staff are appropriate, to meet the assessed needs of residents.
- ensuring effective systems in are place to monitor the premises, fire precautions, care planning, medication management, infection control, and records, which are detailed under the relevant regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of incidents was maintained in the centre. Based on a review of incidents, the inspector was satisfied that all notifications were submitted as required by the regulations to the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in the centre, which was displayed at the reception. There was a to oversee the management of complaints. The inspector viewed a sample of complaints, all of which had been managed in accordance with the centre's policy.

Judgment: Compliant

Quality and safety

The inspectors found that overall, residents were supported and encouraged to have a good quality of life in Lystoll Lodge Nursing Home, which was respectful of their wishes and choices. While good levels of compliance were found in most of the regulations and standards, there were some opportunities for further improvement in care planning, infection control, medication management and maintenance of the premises.

Residents received a good standard of health care and services were provided in line with their assessed needs. There was evidence of regular medical reviews and

referrals to specialist services as required. The centre also had access to the Kerry Integrated Care Programme for Older Persons, via the health Service Executive. This service provided residents access to a multidisciplinary healthcare team, if they were at risk of emergency department attendance. The aim being to manage these residents within the centre, and avoid hospital attendance. Admissions to the designated centre were based on a comprehensive pre-assessment, to ensure the centre could meet the needs of the residents. Care plans were comprehensive, person-centred and reviewed at four monthly intervals. However, some care plans were not always updated if the resident's condition changed. There was evidence that residents and families were consulted with regarding individual care planning.

Residents and staff in the centre had been through a very challenging time during the COVID-19 pandemic, and had been successful in preventing an outbreak in the centre. The centre had a COVID-19 resource folder, however, the COVID-19 contingency plan required updating, and although improvements were noted in infection control practices, since the previous inspection, some further areas required attention, which is discussed under regulation 27.

Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. The centre maintained a register of controlled drugs, which was checked and signed twice daily by two nurses. Medication reviews and pharmacy audits took place on a regular basis.The practices in relation to prescriptions required more effective monitoring, which is discussed under regulation 29.

The provider had measures in place to ensure residents were safeguarded from abuse with appropriate protections. The reporting system in place was clear, and ensured any disclosures or suspicions were escalated and investigated without delay. All allegations of abuse were reported to the Chief Inspector in a timely manner. Where residents were predisposed to significant episodes of responsive behaviours, they were responded to in an appropriate manner by staff, and care plans were comprehensive and person centred. Restraint was being effectively monitored by the management team.

The provider had proactive measures in place to protect residents and others from risk of fire. Fire fighting equipment was available throughout the building. Emergency exits were clearly displayed and free of obstruction. Daily and weekly fire safety equipment checking procedures were completed, however, there were some gaps noted. There was a preventive maintenance schedule of fire safety equipment, the fire alarm and emergency lighting, in accordance with the recommended frequency.

Regulation 11: Visits

Visits were seen to take place in line with updated visiting guidelines, and there were robust procedures in place on entering the centre. Many visitors were seen

coming and going on the day, with visits taking place both indoors in residents rooms, and in the garden. There was sufficient space and time allowed for residents receive their visitors in private. Visitors confirmed that they were communicated with by management, in relation to any changes to the visiting procedures.

Judgment: Compliant

Regulation 17: Premises

Action was required in respect of the following:

- the ventilation system in the smoking room required review as it was not effective. The odour of smoke was present along the West Wing corridor on the first floor, where the smoking room was situated.
- some bedroom walls and door frames required painting, as paint was chipped.
- privacy curtains in some twin rooms required to be realigned, to ensure privacy and dignity of residents was assured.
- two chest of drawers were found to be broken.
- one bed had a frayed electrical cord
- one residents bathroom required a new toilet seat, as the current one was broken.
- two commodes were rusty, therefore effective cleaning could not be assured.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents' nutrition and hydration needs were assessed and closely monitored in the centre. There was good evidence of regular review of residents' by a dietitian and timely intervention from speech and language therapy when required. Comprehensive care plans were in place to support people with their nutrition needs and weights were completed in line with best practice. Intake and output records were maintained, at the point of care, to support nutritional and fluid intake.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy included specified risks and a live risk register was in

place which included identified risks and the mitigating controls in place. A major emergency plan was in place and there was evidence that where an incident occurred, reviews which identified learning were completed and informed the risk register. Maintenance records showed that all equipment was serviced on a regular basis.

Judgment: Compliant

Regulation 27: Infection control

While there were numerous examples of good practice observed on the day, the following areas required improvement;

- the use of shared items such as communal slings for hoists was not appropriate, and the decontamination procedures in between each use were not clear.
- the system in the laundry required review, to ensure laundry was segregated appropriately, to reduce the risk of cross contamination.
- the COVID-19 Contingency Plan was not updated with the most recent guidance from the Health Protection and Surveillance Centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were required pertaining to the following:

- ensuring that daily fire checks were complete, as there were gaps in some days evidenced and records were duplicated.
- scorch marks were observed on a chair in the smoking room, indicating that further assessment of residents who smoked was required, to ensure that effective actions were taken to mitigate risk.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Improvements were required in the following:

- ensuring that prescriptions were signed on medication administration records by the prescriber, as per the centres policy.

- when medication has been discontinued, documentation clearly indicates this and staff were aware of alterations.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans were generally informative and included pertinent information to guide care delivery. However, of a sample of care plans reviewed by inspectors it was found that Improvements care plans were not always updated to reflect advice from allied health services, such as speech and language therapists.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence-based health care provided in this centre. The general practitioner routinely attended the centre and was available to residents Monday to Friday. There was evidence of ongoing referral and review by allied health professionals as appropriate. The provider employed a physiotherapist, who attended the centre once per week.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff identified residents who might display responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Residents had behavioural support plans in place, which identified potential triggers for behaviours and any actions and therapies that best supported the resident. Residents had access to psychiatry of later life. Inspectors observed that staff demonstrated knowledge and skills to respond and manage responsive behaviours in a manner that was not restrictive. Some staff were due training in responsive behaviours, which was scheduled in the coming weeks.

Judgment: Compliant

Regulation 8: Protection

Staff who communicated with the inspectors, were aware of how to identify and respond to alleged, suspected or actual incidents of abuse. Residents reported that they felt safe within the centre. The provider had taken all reasonable measures to ensure residents were protected from abuse. The provider did not act as a pension-agent for residents at the time of this inspection. A vetting disclosure, in accordance with the National Vetting Bureau (Children And Vulnerable Persons) Act 2012, was in place for all staff. Training in safeguarding was provided to all staff, on a yearly basis.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence of resident rights and choices being upheld and respected. Residents were consulted with on a daily basis and at three monthly residents meetings. A programme of activities was available for residents, which they spoke positively about. However, the absence of activities available to residents on the ground floor required review, which is addressed under regulation 15 of this report. Advocacy services were available as required. There was a named resident representative, who spoke on behalf of all residents in the centre.

Judgment: 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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially 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	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0032528

Date of inspection: 01/09/2021

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: The Person in Charge is currently completing Management Course which will be completed by 08.11.2021 and will satisfy regulatory requirements	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A recruitment drive is ongoing within the Home. A resource redeployment analysis has been conducted by the provider which has resulted in reconfiguration of the rota to facilitate additional staff presence in the home as required throughout the day. An additional Activities Assistant has been employed by the centre and commenced in post on 28.09.2021	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Additional staff training in safeguarding and responsive behaviour took place on 08.10.2021 with an a second scheduled for 15.10.2021. A training schedule for the	

remainder of the year has been agreed with the training consultant.

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff files are undergoing a review which is overseen by the Provider. The General Manager will provide a sign off for all staff files to ensure all documentation is present as is outlined in the regulations	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Deficits in staffing levels and skill mix have been addressed by the Provider in the Resource Redeployment Analysis and ongoing recruitment drive as is discussed above. An audit system is in place within the centre , a more robust audit schedule has been developed by the Provider. Audits completed and actions assigned now require monthly sign off by the PIC and quarterly review by the Provider	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Painting of the building commenced on 11.10.2021. All rusty commodes have been removed and replaced with new models. All privacy curtains have been realigned and a weekly audit of same is being conducted by the Head of Housekeeping. All frayed equipment, furniture has been removed and replaced Service engineer on site conducted review of all beds, hoists and wheelchairs on 13.10.2021 Head of housekeeping designated responsibility for review of any maintenance work which may need to be completed and this is reported daily to the provider	

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
All communal hoists and slings have been removed and replaced with universal disposable slings. All residents requiring daily assistance of hoist have been assigned individual slings.
A system for the laundry unit is currently being developed with designated "clean" and "dirty" pathways displayed as per HBN guidelines
The COVID 19 Contingency plan was updated on the day of inspection to include up to date HPSC guidelines

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Daily fire checks have been assigned to the nurse on duty which are audited weekly by the provider
All smoking risk assessments have been reviewed by the PIC and actioned accordingly

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A named Clinical Nurse Manager has been assigned responsibility for ensuring that any changes made to prescriptions are signed off by GP's as outlined in the homes policy.

When medication is discontinued this is documented clearly on the residents Kardex and reflected in the nurse's communication book and residents' notes, the named Clinical Nurse Manager will audit this process weekly

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: Care Plan audits are conducted by CNM on duty. As per the audit schedule care plans will be reviewed monthly by the PIC and quarterly by the provider. The Care Plan audit has been updated to include allied health professional updates as appropriate.	

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 14(6)(b)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a post registration management qualification in health or a related field.	Not Compliant	Orange	08/11/2021
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	15/10/2021

	have access to appropriate training.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2021
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	31/12/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2021
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	Substantially Compliant	Yellow	31/12/2021

	Authority are implemented by staff.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	18/10/2021
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	18/10/2021
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	30/11/2021