Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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 Limited
Address of centre:	Skehenerin, Listowel, Kerry
Type of inspection:	Unannounced
Date of inspection:	18 April 2018
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0022402

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.

Current registration end date:	09/12/2019
Number of residents on the date of inspection:	42

How we inspect

To prepare for this inspection the inspector or 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
18 April 2018	12:00hrs to 18:30hrs	Mary O'Mahony	Lead
19 April 2018	09:00hrs to 17:30hrs	Mary O'Mahony	Lead

Views of people who use the service

Residents with whom inspectors spoke were happy to live in a centre within their locality and to have access to the town and visitors. They praised the staff, the healthcare and the accommodation. They informed inspectors that they were facilitated to exercise choice and to maintain control over their daily lives. For example, they had choice at mealtimes, bedtime and activity involvement. The majority of residents had single or double room accommodation which they said was a great advantage for their privacy. Residents spoke with inspectors about local and national events especially the horse fair and Listowel races. All residents were encouraged to participate in the social life of the centre.

Residents stated that they enjoyed a range of activities which were organised and led by the activity coordinator. On the afternoon of the second day of inspection the physiotherapist attended on his weekly visit, which residents said was very popular as the exercises promoted independence and sense of general well-being. A therapist was also present during the inspection. She was seen to provide individual hand massage and conversation with residents. Inspectors spoke with the therapist who explained the benefit to residents of the individual time and attention they received during the interaction. Residents said that they also enjoyed the regular music sessions, art classes and bingo.

Residents informed inspectors that the location of the centre was lovely as it afforded views over the hills and mountains. The building was set in well-maintained gardens. Mobile residents said that they had independent access to outdoor walks according to their mobility and other relevant assessments. Residents were also encouraged to go out with family members and to celebrate special occasions in the centre.

Capacity and capability

While there were clear lines of accountability and authority in place in the management structure a number of risks identified under the Quality and Safety dimension of this report indicated that the management system did not always identify inadequacies in the audit system which had been put in place to ensure that the service provided was safe, appropriate and consistently monitored.

The person in charge was newly appointed since the previous inspection. She was suitably qualified and was supported by a nursing and healthcare team and an administration staff member. She held regular meetings with the provider and staff members to ensure that staff were aware of their responsibilities of their

respective roles. Incident recording and investigation processes were established and events were reviewed and audited to inform learning. Nevertheless, ongoing areas of risks and non-compliance were identified on inspection.

Feedback from residents' meetings and residents' surveys were included in the annual review of the safety and quality of care delivered to residents. Quality management measures such as management meetings and audits had been set up to demonstrate that the service provided was safe and effective. There was evidence that the quality of care was monitored as audits had been undertaken in areas such as falls and the use of restraint. While the provider had put a system in place to provide a clear oversight of the service provided inspectors found that it did not adequately identify omissions in documentation and notifications. For example, where there was a regulatory requirement to notify the Chief Inspector regarding relevant incidents, inspectors found that a small number of incidents had not been reported as required. The frequency of reporting had improved since the previous inspection however.

The centre provided a comprehensive guide that included information on residents' rights and the complaints process. Residents were given contracts on admission to the centre which reflected these arrangements. The protocol for complaints management was displayed at the entrance to the sitting room. The lack of clarity in relation to the appeals process in the complaints protocol was discussed with the provider: the person in change was named a a member of the appeals panel eventhough she was also the complaints officer. This may have resulted in an perceived lack of independent oversight. An independent advocacy service was referred to in the complaints protocol but was not legible to the majority of residents as the print was small and the notice was displayed above their eye-level. There was an unresolved complaint being investigated at the time of inspection and relevant staff had arranged a meeting with the complainant in an effort to resolve outstanding issues.

Staff meetings and handover reports ensured that information on residents' changing needs was communicated effectively. Supervision was implemented through monitoring procedures such as appraisals. There was evidence that most staff had received training appropriate to their roles, for example, nutrition, infection control and medication management. Inspectors spoke with a large number of staff members who were knowledgeable of the training they had received and the supporting policies. While a number of staff had been provided with updated knowledge and skills in managing the behaviour and psychological symptoms of dementia (BPSD) a number of staff had yet to receive this mandatory training. In addition, mandatory training on the prevention of elder abuse had not always been delivered by a suitably qualified trainer in the subject. Nevertheless, staff spoken with were aware of their statutory duties in relation to the general welfare and protection of residents.

Good systems of information governance were in place. Copies of the standards and regulations were available and accessible to staff. Maintenance records were in place for equipment such as hoists and fire safety equipment. Records and documentation as required by Schedule 2, 3 and 4 of the Regulations were securely

stored, well maintained and easily retrievable. Residents' records such as care plans, assessments, medical notes and nursing records were, on the whole, detailed and relevant.

A sample of staff files was reviewed. Files were found to contain all the necessary documentation including the required An Garda Síochána vetting (GV) clearance. The person in charge confirmed that staff were required to have this prior to taking up employment in the centre. Policies on staff recruitment and training supported robust staff recruitment, including a supervised probationary period. Staffing levels were not always maintained at optimal levels however. Inspectors requested the provider to review the staffing level on night duty as there was only one qualified nurse on duty with three care assistants from 22.00 to 08.00. As the building was two-storey this meant that the staff nurse had to administer night medications to all 48 residents as well as attend to care issues and supervise staff on both floors. Comments were recorded from residents which indicated they were ringing the call-bell for extended periods as staff were very busy and rushed at that time. Inspectors were present on one occasion during the day when a resident was ringing his bell. It was not answered within an acceptable time-frame which meant that inspectors had to call a staff member to attend to the resident. Staff also told inspectors that on a number of occasions when a day staff member was absent on sick leave there had been no replacement available. This meant that staff were rushed and were not always able to give the required attention to residents.

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels required review. Staffing levels impacted on workload, on supervision upstairs and at night-time and on timely assistance to residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Not all staff had the required mandatory training including training on the management of BPSD.

Training on prevention of elder abuse was not always delivered by a suitably qualified person in that area.

Judgment: Not compliant

Regulation 19: Directory of residents

The records in the directory were well maintained.

Judgment: Compliant

Regulation 21: Records

Medication errors, such as medications administered without a staff signature, were not all recorded.

A copy of all required notifications was not maintained.

Not all policies were adopted and implemented, such as the medication policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

Resources for staffing, repairs and suitable equipment required review.

Inspectors were not assured that the system in place to provide assurance service provided was safe, appropriate and consistently monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose was in compliance with the requirements of Schedule 1 of the Regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all notifications had been submitted to HIQA.

Judgment: Not compliant

Regulation 34: Complaints procedure

Clarification was required in the complaints protocol. The satisfaction or not of each complainant was not always recorded.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Not all policies were implemented and adopted as per the protocol set out in the policy.

Judgment: Substantially compliant

Quality and safety

While overall, residents were supported and encouraged to have a good quality of life which was respectful of their wishes and choices, inspectors found that there were periods of time when residents, particularly in the upstairs sitting room and bedrooms, were alone for long periods of time. This was particularly evident after lunch when five staff went to break together. As there was only one staff member available to coordinate activities in both the upstairs and downstairs sitting rooms it was difficult for all residents to be occupied in meaningful activity and social conversation throughout the day. Inspectors found that generally staff were based downstairs once the morning care was done except for meal times. This impacted on the staff presence available to residents, for example, when a resident rang the bell after tea a staff member had to come upstairs to attend to the resident which resulted in a delay in response time. Prior to the bell ringing the 30 residents upstairs were unattended as other staff had gone on to tea-break.

Opportunities for social engagement were provided to groups of residents and they

were seen to especially enjoy the music and singing. Residents were seen to be engaged in activities over the course of the inspection including art class, individual therapy and physiotherapy. Residents were also seen to spend periods of time in their bedrooms as well as in the communal sitting areas watching TV, meeting with visitors or listening to the radio. Residents were facilitated to engage in activities outside the centre including home visits. Information was recorded daily in relation to residents' social care needs. Residents looked happy and relaxed when engaging with staff and inspectors observed a respectful approach by staff when communicating with residents.

Residents had comfortable, spacious accommodation. The majority of bedrooms were single or double en-suite rooms with appropriate storage facilities. Bedrooms and communal rooms had good natural light and many rooms overlooked the local countryside. Room decor and contents were personalised and were equipped with TV, radio, and phone. Residents had been provided with a locked facility in their bedroom for the safe storage of personal money. While the decor was generally of a good standard inspectors observed stained ceiling tiles on some bedrooms and scuffed paintwork on wall and the doors of one bedroom. In addition, furniture in one bedroom was broken. This meant that the environment for the resident involved was not comfortable or well maintained.

Inspectors found that residents' healthcare and nursing needs, including care at end of life, were met to a good standard. Care plans were individualised and staff spoken with had a good understanding of the needs of each resident. General practitioners (GPs) attended the centre regularly. Allied health services, such as physiotherapy, palliative care specialists and speech and language therapy (SALT) were accessible. Clinical assessments took place using evidence-based tools, such as the MUST (Malnutrition Universal Risk Management) tool, and most care plans were reviewed when any change was indicated. Although residents' needs were generally met to a good standard inspectors found that the services of an occupational therapist (OT) were not readily available to assess and meet the seating requirements of residents, in a timely manner. This resulted in a resident being required to spend extra days in bed as he was waiting for a suitable chair to be provided to support his posture and specific needs. A further consequence of the delay in the availability of OT expertise and appropriate seating was a comparatively high use of lap-belts to maintain a safe sitting position. This had the effect of preventing residents getting up when they felt like changing position and they were dependent on staff or the visiting physiotherapist for this support.

Medicine management audits were undertaken and the use of psychotropic medicines was monitored. Arrangements were in place in relation to accessing pharmacy services. Relevant training was provided in medicine management for the nursing staff. Inspectors reviewed documentation in relation to medication errors and found that while these were addressed and appropriately recorded, there were a number of omissions in recording the count of controlled drugs. 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 medicines management. A comprehensive audit of controlled drugs in use in the centre was required to assure management that gaps in

recording had not resulted in errors for residents. Inspectors also found that the practice of checking these drugs at the changeover of each shift by both nurses did not follow the required guidelines and again this had the potential for a serious error.

Policies and procedures relating to risk management and health and safety were seen to be specific to the centre. Inspectors viewed the risk register and found that there were some risks which had not been assessed or updated, a number of which related to potential fire safety risks related to the smokers' room and the above poor medication practices. There was an emergency plan in place. Call-bells were fitted in all rooms. Emergency exits were clearly identified and unobstructed. Daily, weekly, three-monthly and other required checks of the fire safety system were carried out, including checks of the fire-safe doors and fire extinguishers. While a personal evacuation plan (PEEPs) had been developed for each resident since the previous inspection, inspectors found that not all staff were aware of the specific evacuation plan for each resident or where to access it. In addition, certificates related to the quarterly servicing of emergency lighting were not available to inspectors on the day of inspection. Inspectors also found that emergency lights in one hallway had been out of order for a period of 10 days before repair was carried out. Nevertheless, a number of staff spoken with were aware of the protocol to follow in the event of a fire and they were found to have attended fire drills.

Staff were seen to implement good infection control practice in relation to cleaning routines, the use of hand-sanitisers and the wearing of personal protective equipment. The centre appeared clean and residents and relatives were very complimentary of this. As a result there was a low incidence of infection outbreak. Relevant staff training was delivered for example, on correct hand-washing technique and the use of personal, protective equipment (PPE).

Safeguarding of residents was supported by training and appropriate policies on the prevention, detection and response to abuse. Staff spoken with were clear in their understanding of the procedure for reporting concerns and there was a zero tolerance to elder abuse in the centre. However, not all training had been delivered by a suitable qualified trainer. In addition, while residents' financial records were generally well managed, inspectors found that similar to findings on previous inspections receipts were not given for all financial transactions in line with best practice, particularly when the office personnel were off duty. This omission was significant in the event of any allegation of financial abuse. While appropriate risk assessments had been undertaken for the use of bed rails inspectors found that in the sample of files checked a risk assessment for one resident had not been updated to reflect the fact that the resident now had a low-low bed and a fall mat in place following a fall. In addition, the resident's bed-rail was still in the raised position on the low-low bed despite the introduction of alternative measures to prevent a further incident. This indicated that the controls in place to prevent a fall for that resident had not been updated, supervised or relayed to staff. A restraint register was in place which staff filled in whenever bed-rails were used to monitor residents' safety.

Regulation 11: Visits

Visitors had open access to the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate storage space for personal possessions.

Judgment: Compliant

Regulation 13: End of life

Residents were supported by knowledgeable staff and palliative expertise at end of life.

Judgment: Compliant

Regulation 17: Premises

Upgrading of areas of the premises such as ceiling tiles, bedroom furniture and painting of some bedrooms was required.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were well nourished and there was adequate choice of meals available.

Judgment: Compliant

Regulation 26: Risk management

All risks had not been reviewed and updated in a systematic manner.

For example, broken furniture, review of bedrail use and impact of poor recording practices in relation to controlled medicines.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was clean and staff were seen to use personal protective equipment and hand-sanitising gel.

Judgment: Compliant

Regulation 28: Fire precautions

The fire-safe chair coverings in the smoking room were now compromised by the presence of holes in the covering which exposed the foam filling thereby creating a fire safety hazard.
Emergency lighting in one hallway had not been repaired in a timely manner.

A heat detector had nor been replaced in the smokers' room in timely manner.

The additional risks created by these events had not been assessed.

All staff were not aware of where to access the PEEPs (personal evacuation) plan for each resident.

Risks of fire had been under-estimated in some cases, for example the consequences of a fire had been scored as low for vulnerable residents who smoked, which resulted in a lower overall risk score for any potential fire related events.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medicine management systems did not always conform to the professional guidelines for nurses and best evidence based practice particularly in relation to controlled drugs and the required signatures for the administration of medicines.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A number of residents care plans required updating in line with residents' current needs.

For example, the continence assessment for a resident had not been updated to reflect the fact that the resident no longer had a catheter in place.

Judgment: Substantially compliant

Regulation 6: Health care

Occupational therapy assessment had not resulted in the provision of a suitable chair for enable a resident to get up daily and to minimise the use of lap-belts.

Judgment: Substantially compliant

Regulation 8: Protection

Receipts were not given for all costs to residents and for all money received particularly at weekends.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were not all aware of the external advocacy service and the information of

this service was not clearly displayed.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially 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 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0022402

Date of inspection: 18/04/2018 and 19/04/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There are four carers on duty from 2000hours to 2200hours. We reviewed the staffing levels on night duty and now have a second nurse on duty until 2200hrs to attend medication, care issues and supervision of staff. We are currently auditing the length of time it takes to respond to a call bell. This will be completed over a period of time and will be part of the audit schedule. This will highlight any extended waiting times. Following this audit corrective action will be implemented. At all times we would attempt to maintain staff quota. It is unfortunate on these occasions when a staff member rings in sick last minute and we are unable to get a replacement either from our current staff quota or agency at such short notice. However the optimal level of care for all residents is maintained within the home during these times.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: BPSD training is provided quarterly and all our staff receive this mandatory training. A small number of our most recently appointed staff did not have this training on day of inspection but they were scheduled to be included on our next quarterly training date the 21st June. All Staff receive elder abuse training annually from a suitably qualified trainer. New appointed staff receive training on induction from our in-house qualified training person	

using the HSE training pack. Due to the updating of elder abuse to safeguarding, our qualified trainer is currently unable to avail of the HSE safeguarding trainer programme. Following contacting the National Safeguarding Office and HSE, this programme is not in circulation currently.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

With regard omissions in the controlled drugs, this is now being monitored closer in which we ensure it is signed at each shift changeover. Comprehensive audits has been undertaken to ensure there are no omissions of medication and this is ongoing on a regular basis.
An omission on a notifiable incident that we omitted to send as detailed in Regulation 31 Notification of Incidents has since been sent to hiqa

Comprehensive audits has been undertaken to ensure all policies are being adhered to.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We reviewed the staffing levels on night duty and two nurses will be on duty until 2200hrs to attend medication, care issues and supervision of staff.
While staff members are on lunch break together, four staff members remain on duty throughout the nursing home during this time.
In addition to the activities coordinator, there are additional entertainment services contracted in daily i.e. music etc.
Staff are distributed throughout the nursing home once morning care is complete.
Although 30 residents reside in our upstairs bedrooms, a large number of these residents use our two downstairs sitting rooms throughout the day.

Since inspection repair work has been carried out, with exception of the ceiling tiles which will be completed in the near future.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

With regard to all notifications not submitted to HIQA, an omission of a notifiable incident has since been sent to hiqa

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Our appeals panel has changed and we have amended our complaints procedure. The print has been enlarged and is displayed at eye level.

The complaints book has been reviewed to include a section for complainant to include their satisfaction or not regarding the outcome of a complaint
With regard to the unresolved complaint, we understand this is now fully resolved and are currently awaiting feedback from the complainant to confirm that complainant is satisfied with the outcome.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Comprehensive audits has been undertaken to ensure all policies are being adhered to.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

With regard to repairs, at the time of inspection we were waiting for another bedroom to become vacant in order to undertake redecoration. This has since been completed.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:

The monthly audit of bedrails will highlight any omissions in documentation and handover of information to staff.
The broken furniture i.e. locker has since been repaired
With regard to poor record practices in relation to controlled medicines, this is now being monitored closer in which we ensure it is being checked and signed at each shift changeover. Comprehensive audits has been undertaken to ensure there was no omission of medication and this is ongoing on a regular basis.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
This maintenance was completed on the first day on inspection. To prevent any reoccurrence of this a smoke detector has been installed in the corridor outside our smoking room.
The armchairs which had exposed foam due to a cigarette burn have since been removed and replaced.
Fire training will incorporate the location of PEEPS and will also be included in the future staff Induction programme for newly appointed staff.
Our servicing of emergency lighting had been done annually. Quarterly servicing is now being carried out as per fire regulations.

The risk register is revised and scores updated since inspection.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

With regard to the controlled drugs, this is now being monitored closer in which we ensure it is being checked and signed at each shift changeover. Comprehensive audits has been undertaken to ensure there was no omission of medication and this is ongoing on a regular basis.

A further audit is in place to monitor staff administering medication and records.

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:

The care plan referred to has been updated to reflect changes in care needs.

Regulation 6: Health care	Substantially Compliant

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

We were awaiting for an OT assessment to enable us to get the appropriate chair. Unfortunately the nursing home had no control over the length of time it would take the HSE to provide an OT for this assessment. Therefore a lap belt had to be used on the current chair to safe guard the resident whilst awaiting this assessment This issue has since been closed

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

We would like to clarify that monies received for fees and other costs are all receipted. A receipt is a document stating a payment has been received regardless of the layout of the document. Our method of receiving payments is as follows; During office hours a computerized receipt is issued. Outside office hours ie; evening and weekends hand written receipts are issued from the receipt book. However, there are a number of our clients who do not want this type of receipt. These clients produce their invoice and request that we write “paid” on it. As this is their preference the nurse receiving the payment will document their invoice to state paid, followed the date, amount received and will then sign the invoice. In addition to the above a further computerized receipt is issued to all clients with their following monthly invoice. Going forward we will issue a receipt from our receipt book to our clients.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Since inspection, posters are displayed throughout the building with information of our external advocacy service.

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 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	31/08/2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	21/06/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	11/06/2018
Regulation 17(2)	The registered provider shall, having regard to	Substantially Compliant	Yellow	31/08/2018

	the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
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	02/05/2018
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/08/2018
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	28/05/2018
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall	Not Compliant	Orange	20/04/2018

	provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/07/2018
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	20/04/2018
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	20/04/2018
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	31/08/2018
Regulation 31(1)	Where an incident	Substantially	Yellow	15/06/2018

	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.	Compliant		
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	11/06/2018
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 and properly recorded and that such records shall be in addition to and distinct from a	Substantially Compliant	Yellow	25/05/2018

	resident's individual care plan.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	31/08/2018
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	08/06/2018
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	08/05/2018
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/09/2018
Regulation 9(3)(f)	A registered	Substantially	Yellow	05/06/2018

	provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.	Compliant		