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:	14 February 2022
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0036207

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, approximately one mile outside the heritage town of Listowel. The centre provides 24-hour nursing care, which is led by the person in charge, who is a qualified nurse. The centre is a two story premises and is registered to accommodate 48 residents. Bedroom accommodation consists of 28 single bedrooms and 10 twin bedrooms. There is a variety of communal space, which includes a dining room on the ground floor and three sitting rooms, as well as an internal garden. The centre can accommodate 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.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	29

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
Monday 14 February 2022	10:00hrs to 18:15hrs	Ella Ferriter	Lead
Monday 7 March 2022	16:45hrs to 20:45hrs	Ella Ferriter	Lead
Tuesday 8 March 2022	09:00hrs to 14:30hrs	Ella Ferriter	Lead
Monday 14 February 2022	10:00hrs to 18:15hrs	Caroline Connelly	Support
Monday 7 March 2022	16:45hrs to 20:45hrs	Caroline Connelly	Support
Tuesday 8 March 2022	09:00hrs to 14:30hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This inspection took place over two days and one evening. The inspectors met with all residents living in the centre throughout the inspection days, and spoke in more detail to ten residents, to gain an insight into their daily life and experience of living in Lystoll Lodge Nursing Home. The overall feedback from residents was that they were happy living in the centre and that staff were exceptionally kind and committed to their care. However, some residents on the first day of the inspection, commented on the absence of activities in the centre and told the inspectors they missed having something to do during the day. Residents reported that this had been the same for a number of months. The inspectors also met with one visitor, who expressed satisfaction regarding the care that their family member received and the dedication of staff.

Lystoll Lodge Nursing Home is situated outside the town of Listowel, County Kerry, in a rural setting. The centre is a two story purpose built red brick building. On entering the building each day, the inspectors were guided through the centre's infection prevention and control procedures, by a staff member. The systems in place were comprehensive, and included a signing in process, hand hygiene and a temperature check. Appropriate signage was present at the reception, regarding the centre's infection prevention and control measures. The inspectors noted that the guidance relating to visiting procedures, displayed on entering the centre, did not comply with the current national guidance, which is discussed further under regulation 11.

Lystoll Lodge Nursing Home is registered to accommodate 48 residents. There were 29 residents living in the centre on the day of this inspection. Bedroom accommodation is over two floors, and comprises of 28 single rooms and ten twin rooms. On day one, the inspectors were guided on a tour of the premises, with the general manager. Overall, the inspectors observed that the premises was clean throughout, and the inspectors saw that the provider had painted the corridors and some bedrooms following the findings of the previous inspection, of September 2021. On the walk around the inspectors noted that some items of furniture, in residents bedrooms, required repair, such as handles of wardrobes and drawers. It was also evident that door numbers were not replaced on some doors, that had been painted, which presented a risk in the event of fire, as rooms were not easy to identify. This was brought to the attention of the management team on day one, and the inspectors saw that many of these areas had been addressed, by day two of this inspection. However, some further areas, pertaining to the premises required attention, which is discussed further under regulation 17.

The inspectors observed, throughout day one of this inspection, that there was no social stimulation provided for residents. The inspectors noted that although it was Valentines day, there were no decorations or any sign of celebration or engagement about the day. Many residents were observed sitting in the same seats all day long, in both the upstairs and downstairs sitting rooms, with little going on and little to do.

Residents told inspectors that the day could be long and often boring. Inspectors were informed that the staff member previously appointed as activities coordinator with responsibility for social stimulation for residents was moved to health care assistant duties and no other staff was appointed. On day two and three of this inspection the inspectors observed that there were activities for residents and an new activities coordinator had been appointed, following the findings of day one. Over day two and day three residents were observed engaging in activities and interaction and the inspectors saw residents laughing and enjoying their day. Activities such as hand massage, singing and arts and crafts were observed to take place. Mass was also available on television for residents in the communal rooms and their bedrooms. Residents told the inspectors that having something to do made their day more enjoyable and made the day go so much faster. One resident said it gave them something to look forward to when they got up in the morning.

Residents reported that they felt safe in the centre and were well cared for by a team of staff who were respectful to their needs and wishes. Staff whom the inspectors spoke with were knowledgeable regarding their role and responsibility in protecting residents from the risk of abuse. The inspectors observed many positive interactions between staff and residents throughout the three days of this inspection. Staff were observed engaging well with residents and it was evident that staff knew residents personal preferences. Residents spoke of the friendliness and kindness of staff and told inspectors how they enjoyed their company. One resident told the inspectors how they looked forward to certain staff being on duty as they were full of fun and brightened up their day/evening. The inspectors saw that there was appropriate supervision in day rooms, which was a noted improvement from the previous inspection.

Inspectors met and spoke with numerous staff working in the centre, throughout the three days. They told the inspectors that they enjoyed working in Lystoll Lodge Nursing Home and were well supported by the management team. Staff spoke very positively about caring for the residents in the centre and told the inspectors that they enjoyed getting to know the residents and their families. There were also staff being inducted, and from speaking to them and inspectors observations, it was evident that there was a comprehensive induction process in place.

The inspectors observed the dining experience for all residents living in the centre. On day one, it was evident that a number of residents were not given the opportunity to attend the dining room. The main dining room, which was downstairs, was observed by inspectors to be not in use by many residents, and was seen to be mainly used by staff. This resulted in residents eating in the sitting rooms, where they sat all day, with a table placed in front of them. Some residents had their meals in their bedrooms, which some said was their personal choice. Residents spoke positively regarding the dinner time food, which was served at one o' clock. However, the inspectors noted that the evening meal started at 16:15, earlier than scheduled and were informed this was due to staffing constraints. On day 1 inspectors observed that this was all completed and cleared away by 16.40. On the evening of the second day of inspection the inspectors arrived to the centre at 16:45 and findings were similar to day one. The tea time was over and inspectors were informed that it was scheduled early, due to staffing constraints. On review of

the menu available, during the course of this inspection, it was evident that there was also a limited choice of food at tea time and the snacks served at 20:00 hrs were not sufficient. This is discussed further under regulation 18. The inspectors noted that the dining space within the centre was limited for 48 residents, upstairs and downstairs, However, there was a new day/dining room being built, which would afford residents with additional dining space.

Residents had easy access to an internal courtyard, which was paved and well maintained. The smoking room had recently been relocated to an external area, at the side of the building and the inspectors saw one resident using this area, over the three days. However, they did not have easy access to the outside and had to request that staff facilitate exit and entry, via the front door. The inspectors observed a resident had to wait for extended periods, for staff to answer the door bell and to have access back into the centre. The inspectors stood outside the door with the resident waiting entry on day two of this inspection for over ten minutes, this is discussed further under regulation 9.

Inspectors sat in on the night handover, on day two of this inspection and were assured that their were good communication processes in place. Information conveyed, relating to residents care was comprehensive and it was evident that their were good systems in place ensuring residents clinical care needs were addressed and being monitored.

The next two sections of the 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

Lystoll lodge had a history of poor regulatory compliance, particularly in relation to aspects of governance and management, complaints management, fire safety and premises identified over the course of a number of years. There had been ongoing interactions between the provider and the Chief Inspector. Although there had been improvements in the overall governance and management of the centre noted on the previous inspection of the centre, undertaken on 01 September 2021, further improvements were required on this inspection in the management of residents finances, sustaining staffing levels and the oversight of food and nutrition. Action was required to ensure the service was safe, appropriate, effective and consistently monitored.

This was an unannounced risk inspection undertaken against the background of concerns relating to the management of residents finances and incidents within the centre. The extent of the concerns of the inspectors, on day one of this inspection, were such that, it was deemed necessary to return, to ensure the safety and welfare of residents in the centre. This was particularly in relation to residents dietary

requirements and management of residents finances.

The inspection was undertaken over two days and one evening, to follow up on information submitted by the management team, via statutory notifications, once the issues became apparent to them. Unsolicited information had also been received, to the Chief Inspector in relation to the centre. The inspectors acknowledge that some of the findings on day one of this inspection were addressed by the management team, and improvements were seen on day two and three. However, these systems were at an early stage of implementation, and continued commitment was required by the registered provider to sustain improvements, and to ensure a quality service for residents was delivered.

The registered provider of the centre is Lystoll Lodge Nursing Home Limited, which is comprised of three directors. The management structure within the centre was clearly defined and identified lines of authority and responsibility. One director works full time in the centre as a general manager and is involved in the operational management of the centre. Previous representation submitted to the Chief Inspector in 2019, in response to a notice of proposal to cancel the registration of the centre, outlined that this director would have full autonomy to run the centre and the other two directors would step back from the day to day operation of the centre. However, the inspectors were informed that the other director's in the company, who were not named in the centres internal management structure were directing some issues such as staffing levels and other resources.

From a clinical perspective, care is directed via a full time director of nursing. They are supported in this role by three Clinical Nurse Managers and a team of nurses, health care attendants, domestic and catering staff. The Chief Inspector had been informed, that the director of nursing had resigned their position, prior to this inspection and were currently working their notice period. The general manger had also resigned their position and were working their notice period. One of the directors met with the inspectors on the second day of the inspection and outlined the plan for the governance structure going forward, including their successful recruitment for replacement posts.

The provider was operating outside their conditions of registration in relation to the operation of the centre. The inspectors saw that a new building attached to the designated centre, which was not registered for use, was found to be in use for staff dining and changing. Following the previous inspection the provider was informed that in order for staff to use this space it was required to be registered and an application would be required to be submitted. An application was not received to date, therefore, the provider was using facilities that were not registered.

There were systems in place to monitor the quality of care. A number of audits were carried out in 2021 which reviewed practices such as care planning, medication practices, the used of restraints and infection prevention and control. Areas for improvement were identified and action plans were put in place. Key performance indicators on information such as wounds, restraint and antibiotics were being collected on a weekly basis and communicated to staff to inform care provision and improve quality. The inspectors attended the handover, which was found to be

comprehensive and assured inspectors that staff communication was good and resident's healthcare needs were being well communicated and met.

The inspectors found that records were stored securely. Records as set out in Schedules 2, 3 and 4 of the regulations and relevant to the regulations examined on this inspection were kept in the centre and were made available for inspection. However, on review of staff files it was evident that not all files conformed with the requirements of the regulations, which is discussed further under regulation 21. It was also found that the maintenance and storage of two residents' financial records, where the registered provider had managed their state pension was not transparent and robust, and did not show the reconciliation of each account, which is discussed further under regulation 7.

The inspectors acknowledged that residents and staff living and working in the centre have been through a challenging time, as they had experienced two COVID 19 outbreaks. The first in September 2021, affected both residents and staff and the other in January 2022, affected staff only. A review was carried out as recommended by the Health Protection and Surveillance Centre (HPSC), regarding the centres management of the COVID-19 outbreak, to identify areas for learning and improvement.

A complaints log was maintained, with a record of complaints received, the outcome and the satisfaction level of the complainant. The complaints procedure was displayed in the centre and contained all information, required by the regulation. Incidents occurring within the centre were well recoded and all had been reported to the Chief Inspector as per regulatory requirements.

Regulation 14: Persons in charge

The provider had submitted a notification to the chief inspector for a person in charge, that did not meet the requirement of the regulations. A condition had been applied to the providers registration to have a person in charge in place that met the requirements of the regulations. At the time of this inspection the provider continued to be non-compliant in this area.

Judgment: Not compliant

Regulation 15: Staffing

This inspection found that staffing levels did not meet the needs of residents. The staffing systems in place were not in line with the centre's statement of purpose.

- There were insufficient staff to meet the social needs of residents. Findings of this inspection were that there were no opportunities for social stimulation for

residents on day one. Improvements were noted by the inspectors on day two and three of this inspection, as the provider has allocated a staff member as an activities coordinator full time. This social stimulation required to be maintained.

- cleaning staff hours had been recently reduced and there was only one cleaner on duty daily, with a second cleaner on duty only two days of the week. Taking into account the size and layout of the centre over two floors this resulted in an inability for cleaning staff to perform deep cleaning of rooms. Deep cleaning schedules had not been completed.

Judgment: Not compliant

Regulation 16: Training and staff development

Although staff were generally supported and facilitated to attend training. A review of training records indicated that there were some gaps evident, for example:

- Four staff did not have safeguarding training
- Two new staff did not have moving and handling training
- 23 staff did not have training in managing responsive behaviours as per the centers policy
- One staff did not have fire safety training and four staff's training was out of date.

The inspectors saw that training was scheduled for infection control and safeguarding vulnerable adults, the week following this inspection.

Judgment: Substantially compliant

Regulation 21: Records

The inspectors reviewed four staff personnel records. One staff file did not have a second reference available for review, which is a requirement as per Schedule 2 of the regulations. This was sourced by day two of this inspection. The systems in place for the management and recording of resident's finances was not sufficiently robust, which is outlined under regulation 9, protection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that the oversight of management systems required improvement to ensure services provided were appropriately monitored and that they met the regulations, evidenced by:

- there was a lack of oversight regarding the systems to manage residents finances, including how some residents access their monies for personal expenditure. What was of concern was that the management team were unaware of financial arrangements for residents within the centre, as it was being managed remotely by the owners of the centre.
- there was a lack of a system of oversight of residents nutritional requirements and residents mealtime experience.
- the management structure within the centre as outlined in the statement of purpose was clearly defined and identified lines of authority and responsibility. One director works full time in the centre as a general manager and is involved in the operational management of the centre. Previous representation submitted to the chief inspector in 2019 in response to a notice of proposal to cancel the registration of the centre outlined that this director would have full autonomy to run the centre and the other two directors would step back from the day to day operation of the centre. However, the inspectors were informed that the other director's in the company, who were not named in the centres internal management structure were involved in determining staffing levels and the use of resources within the centre. The inspectors identified that the provider had not ensured that the centre had sufficient resources, with regards to staffing as detailed under regulation 15.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Each resident had a written contract of care that included the services provided and fees to be charged, including fees for additional services.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in Schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified.

Judgment: Compliant

Regulation 34: Complaints procedure

An centre-specific complaints policy was in place. The complaints policy identified the nominated complaints officer and also included an independent appeals process. A summary of the complaints procedure was displayed. Procedures were in place to ensure all complaints were logged, investigated and the outcome of the investigation was communicated to complainants.

Judgment: Compliant

Quality and safety

This inspection found that residents in Lystoll Lodge Nursing Home received a good standard of nursing and medical care, from a team of staff who knew their individual clinical needs and preferences well. However, the rights of residents including the right to social care were not met in line with their capacity and preferences. Improvements were also required pertaining to protection, food and nutrition and infection control.

The inspectors were assured that the care delivered to the residents was of a good standard, and that staff were knowledgeable about residents care needs. Overall, care plans provided guidance to staff and were detailed with holistic and person-centred information, to guide care delivery. However, some improvements were required, which are discussed further under regulation 5. Residents had unrestricted access to a General Practitioner (GP) and records reviewed evidence that residents were supported to meet with their GP in the centre when required or requested. The provider employed a physiotherapist who attended the centre one day per week. Residents also had access to chiropody, occupational therapy, dietetics, and speech and language therapy. There was a low incidence of pressure ulcer development within the centre. Gaps were identified in wound care assessment which is discussed further under regulation 6.

Residents identified as nutritionally at risk were appropriately assessed and referred to dietitian services for further assessment. Where specific dietary requirements were prescribed, they were seen to be implemented. However, as mentioned earlier in this report the inspectors were not satisfied that residents were offered an appropriate diet in the evening time, which is discussed further under regulation 18.

Infection prevention and control measures were in place in the centre. Staff had access to appropriate training and further training for infection and control was scheduled for the week following this inspection. Staff who spoke with the

inspectors were knowledgeable in signs and symptoms of COVID-19 and the necessary precautions required. Good practices were observed, with hand hygiene procedures and appropriate use of personal protective equipment. However, some policies relating to with infection control were not being followed which will be discussed under Regulation 27.

Improvements were noted in the oversight and monitoring of fire safety since the previous inspection. The premises overall was bright and clean. It was evident that areas identified on the last inspection that required to be addressed pertaining to the premises such as painting and the replacement of equipment had been actioned by the provider. Some further areas identified for improvement pertaining to the premises required attention, which are discussed under regulation 17.

Residents meetings were taking place in the centre every three months and their was evidence that where suggestions were made they were acted on by management. Residents had access to an independent advocacy service and it was evident that residents were supported and encouraged to use this service. The team of staff working in the centre were committed to a rights based approach to care and advocated for residents in relation to areas such as planning their discharge home and sourcing funding for equipment such as specialised chairs. However the social care needs for residents were not being met and their right to independence with their finances required action and this is outlined under Regulation 9.

The processes in place pertaining to the management of residents finances were not sufficiently robust and the provider had not taken all reasonable measures to protect residents from financial abuse. This is discussed further under regulation 8.

Regulation 11: Visits

Residents were supported to maintain personal relationships with family and friends. However, the centre was not facilitating visiting in line with the current COVID-19 HPSC guidance on visits to long term residential care facilities, and visits were limited. External signage in relation to visiting procedures in the centre was outdated. Each residents had a visiting care plan implemented, in accordance with current guidance. The inspectors did not have the opportunity to meet with any visitors on day one of the inspection but did meet one visitor on the evening of the second part of the inspection.

Judgment: Substantially compliant

Regulation 17: Premises

The following issues pertaining the premises required to be addressed:

- the premises did not have adequate staff changing and dining facilities and staff were seen to be using a new building attached to the designated centre, which was not registered for use.
- the inspectors saw that door handles of wardrobes required to be repaired in some rooms. On day three of this inspection the inspectors were informed that all bedrooms were being fitted with new wardrobes.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There were a number of issues identified with quantity, nutritional value and lack of choice at mealtimes that required to be addressed:

- there was limited choice available for residents for their evening/tea time meal. For example, on day one of this inspection residents were offered sausages, which had also been on the menu for residents that day for lunch. On day two of this inspection residents were offered soup and sandwiches with no other option. Residents requiring textured or modified diets were provided with thickened soup.
  the inspectors found that the evening/tea time meal was served very early, and this was due to staff arrangements and not residents needs
- there was a significant gap between tea time and breakfast served the next morning from 08.00hrs.
- inspectors were not satisfied with the nutritional value of the suppertime offering, particularly as the evening meal had been served so early and was limited in choice. Inspectors observed food offered at 19:00hrs as tea and biscuits, provided in a softened form, for residents on special diets.
- residents were not given the choice or opportunity to have a dining experience and were seen to have their meals in the chairs where they sat all day.

The inspectors requested that a full dietary review of the existing menu be carried out by a qualified professional and be submitted following this inspection.

Judgment: Not compliant

Regulation 27: Infection control

While there were arrangements in place to manage infection control arrangements in the centre, some practices were not in line with the national standards as identified by the inspectors during the inspection including:

- as per the findings of the previous inspection, the layout of the laundry required review, to did not ensure that there was segregation of clean and soiled linen.
- the centre could not be effectively deep cleaned due to the recent reduction of cleaning staff hours as seen by records of uncompleted cleaning schedules
- some hand sanitizers in the centre were found to be empty on corridors on all three days of this inspection.
- the staff changing facilities were cluttered and their were no cleaning records available for this area.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspectors followed up on the area of non compliance identified the previous inspection of September 2021, which had found that daily fire checks were not always completed. The systems that were in place, including the allocation of responsibility for this, required review. The provider had improved these systems, following these findings, and on review of records it was evident that daily and weekly fire safety checks were now taking place.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Examples were seen where individual assessment and care planning were not reflecting residents current needs, as it was found:

- not all care plans were updated four monthly, as per regulatory requirements.
- a behavioural support care plan for a resident did not accurately reflect their needs and requirements.
- a urinary catheter care plan did not have sufficient detail in place to direct care requirements.

Judgment: Substantially compliant

Regulation 6: Health care

Documentation and assessment of wounds were not completed with sufficient detail to ensure that they were effectively monitored and residents needs were met. The

inspectors acknowledge that new wound management systems were put in place, following day one of this inspection. However these were at an early stage and would require further training and implementation by all staff.

Judgment: Substantially compliant

Regulation 8: Protection

Reasonable measures to safeguard residents were not in place in relation to resident's finances, and examples were seen where the safeguarding policy was not followed. This is evidenced by:

- the systems in place for the management of resident's finances was not sufficiently robust. The provider was acting as a pension agent for some residents living in the centre. However, accrued monies in these specific accounts were not made available to the residents and in fact the residents were unaware of monies accrued as they were not receiving their own statements. This meant that residents did not have the opportunity or choice to spend their money. One the management team became aware of this they engaged with an advocacy service, to represent residents and assist them to set up individual accounts.
- the current system for invoicing residents for services such as hairdressing and chiropody was not robust as proof of receipt of the service was not available and individual receipts were not maintained on residents files for these services.
- the system in place for the management of residents monies and items handed in for safekeeping was not sufficiently robust. Monies were recorded on envelopes which were often thrown away after use leaving no record of monies lodged or withdrawn. Signatures were missing from a number of transactions of receipt and payments of monies to residents and the above practices did not protect the resident or staff member.
- the provider has notified the Chief Inspector of a number of safeguarding concerns within the centre, however, these were not referred to the HSE safeguarding team, as per the centres policy.

The inspectors acknowledge that following these findings of day one, the registered provider implemented a more robust process of managing residents finances. They also contacted HSE safeguarding team.

Judgment: Not compliant

Regulation 9: Residents' rights

Findings of this inspection in relation to residents rights were as follows

- There were no opportunities to participate in activities in accordance with residents interests and capabilities place in the centre on the first day of the inspection and the social care needs of residents in the centre, were not being met. The inspectors were informed that there had not been any staff allocated to provide social stimulation for residents for the past three months. Although there were improvements on the second part of the inspection, and an activities coordinator was appointed, this level of social activities for residents needed to be sustained.
- Limits to exercising choice to go outside as, although residents had easy access to the external courtyard, one resident who went out regularly around the front of the building had to ask staff to leave them in and out of the front door. The resident should have had access to the door code so they could come and go as they pleased.
- some residents could not exercise their rights in relation to finances due to poor financial systems. Residents did not have access to, or were not aware of, money they had available to them. Therefore they were not given the opportunity to exercise choice on how to spend this money.
- examples seen where residents could not carry out activities in private as curtains seen not to fully enclose some bed spaces in some twin bedrooms which did not provide privacy and dignity for the residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	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	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0036207

Date of inspection: 03/03/2022

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: A new person in charge commenced their role 04.04.2022 who meets the criteria as set out in regulation 14.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing levels are kept under constant review by the centre in order to meet the dependency needs of the residents. A full time activities coordinator has been engaged by the centre to ensure an enhanced programme of social activities is available. Rostered hours of cleaning staff have been increased to facilitate deep cleaning and documented schedules associated to this are now in place.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff training that was outstanding specified during the inspection has been organised for	

all new and existing staff.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All staff files have been updated with the required documentation, and are now in full compliance with regulation 21.

Regular audits will be commenced to ensure compliance with the regulation for all new and existing staff.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A new resident finance policy has been put in place which outlines clear procedural and audit guidelines regarding the management of resident finances. A resident transaction log has been put in place within the centre in accordance with this policy which details any and all lodgment and withdrawls of resident monies maintained by the centre.

A nutritional and dietetic review has been commissioned by an appropriate external consultant to ensure all meals provided are appropriate to the individual nutritional care needs of all residents. Please also refer to regulation 18.

Since the 4th of April 2022 a new person in charge was appointed to the centre that meets the criteria set out in regulation 14. This person has also been appointed to the board of the company and fulfills the role of registered provider representative.
Individuals at all levels of the company are afforded the appropriate autonomy by the company in order to deliver safe and effective care to all residents.
The companies governance and management structure has been reviewed and now sets out in detail the roles and responsibilities of all employees at all echelons of the company.
In line with autonomy the employee has relative to their role, employees are permitted to expend monies and allocate resources as required to meet the care needs of all residents.
There is a scheduled board and management meetings on a monthly basis which will review all aspects of clinical care and non-clinical services.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
Out of date visiting guidelines were removed from the front door on the date of inspection.
Visiting now occurs within the centre as per up to date HSPC and HSE guidelines.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A staff dining facility has been put in place on the west wing of the nursing home.

Provision has been made for welfare facilities for staff within the centre. These welfare facilities shall be further enhanced on the completion of new building works.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The current menu for residents was revised post inspection.
The menu now in place was audited by an external specialist consultant.

There findings compiled into a report which identified that the menu submitted for analysis is nutritionally complete, providing an excellent variety of foods from each of the main food groups, including breads and cereals, meat and alternatives, fruit and vegetables, milk and dairy. The current menu reflects meals that are acceptable to the residents and offers variety in terms of taste, consistency and colour of the food served to residents. The current menu also supports options for diets tailored around medical conditions including diabetes, gluten free, texture modified and fortified diets. Overall, the menus achieved a 91% compliance rate as per the audit completed with recommendations to achieve an even higher level of compliance going forward.
Nutritional training for all staff has been arranged to ensure awareness and compliance with the nutritional requirements of all residents within the centre.

Meal times have been changed to ensure there is no significant gap between tea time which is now 5pm and breakfast served the following morning. Residents are also provided further snacks between 7pm and 8pm along with an additional supply of snacks kept available for residents who request or require additional intake overnight.

Dining experience audits shall be completed on a regular basis by the Person in Charge or appointed deputy to ensure compliance with the findings of the external report completed and regulation 18. Additional dining room facilities have been identified in line with the ongoing construction works at present to expand the existing area for residents to have meals. All residents care plans will reflect the residents preferred choices on where they wish to dine.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. An internal review of the existing operations of the laundry shall be completed. In the medium to long term the centre intends to put a new laundry structure in place by 31.10.2022.
2. Rostered hours of cleaning staff have been increased to facilitate deep cleaning and documented schedules associated with this are now in place.
3. New dispensers are to be installed in all areas of the Nursing Home for Hand Sanitizer by 14/05/22. These shall be checked daily by housekeeping staff for sufficient supply.
4. Provision has been made for welfare facilities for staff within the centre. These welfare facilities shall be further enhanced on the completion of new building works.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1.The care plans identified during inspection have been updated within the specified timeframe.
Monthly Care Plan audits shall be put in place to ensure compliance.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Documentation and assessment of wounds for all residents is up to date at present and will be under constant review from
Regular clinical reviews are being completed by Clinical Nurse Managers with oversight from the Person in Charge.
The centre is also supported by Tissue Viability Nurse's both public and private.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A new resident finance policy has been put in place which outlines clear procedural and audit guidelines regarding the management of resident finances. A resident transaction log has been put in place within the centre in accordance with this policy which details any and all lodgment and withdrawls of resident monies maintained by the centre.

Invoices for chiropody, hairdressing and other similar services shall be maintained individually on file for all residents.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A full-time activities coordinator has been recruited to the centre.

The resident referred to in the report has been provided with the front door keypad code. This keypad requires repositioning to ensure the resident has adequate access.

A new resident finance policy has been put in place which outlines clear procedural and audit guidelines regarding the management of resident finances. A resident transaction log has been put in place within the centre in accordance with this policy which details any and all lodgment and withdrawls of resident monies maintained by the centre.

A review of all privacy cutrains in place for double occupancy rooms shall be completed to ensure all privacy curtains are fit for purpose and ensure the privacy and dignity for all residents sharing a room is mainrtained.

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	04/04/2022
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	04/04/2022
Regulation 15(1)	The registered provider shall	Not Compliant	Orange	12/04/2022

	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.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2022
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	31/07/2022
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	12/04/2022
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Not Compliant	Orange	12/04/2022
Regulation 18(2)	The person in charge shall provide meals, refreshments and	Not Compliant	Orange	12/04/2022

	snacks at all reasonable times.			
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	30/04/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30/04/2022
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	Not Compliant	Orange	30/04/2022

	effectively monitored.			
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 staff.	Substantially Compliant	Yellow	31/10/2022
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	30/04/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional	Substantially Compliant	Yellow	30/04/2022

	guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	12/04/2022
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	22/02/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	22/02/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	15/04/2022
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/05/2022