

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	Lystoll Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000246
<b>Centre address:</b>	Skehenerin, Listowel, Kerry.
<b>Telephone number:</b>	068 24248
<b>Email address:</b>	lystoll.lodge@gmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Lystoll Lodge Nursing Home Limited
<b>Provider Nominee:</b>	Margaret Mulvihill
<b>Lead inspector:</b>	Mary O'Mahony
<b>Support inspector(s):</b>	Mary Costelloe
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	46
<b>Number of vacancies on the date of inspection:</b>	1

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

**Compliance 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 Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
11 May 2016 09:30	11 May 2016 20:00
12 May 2016 09:15	12 May 2016 14:00

The table below sets out the outcomes that were inspected against on this inspection.

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Substantially Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

This inspection of Lystoll Lodge by the Health Information and Quality Authority (HIQA) was announced and took place over two days. The provider had applied to renew registration of the centre. As part of the monitoring inspection, inspectors met with residents, relatives, the provider, the person in charge, administration staff and staff members. Inspectors observed practices and reviewed documentation for

example, care plans, medical records, training records, policies and procedures and staff files. The provider and person in charge had been responsive to actions required from previous inspections. There were 46 residents in the centre during the inspection, one resident was in hospital and there was one vacant bed.

Inspectors found the premises, fittings and equipment were of a high standard and the centre was clean and well maintained. There was a good standard of décor throughout and communal rooms were newly painted. Pre inspection questionnaires sent by HIQA prior to the inspection, were reviewed by inspectors and these confirmed that relatives and residents were content with care in the centre.

The centre had employed an activities coordinator who provided a wide variety of social and recreational activities which were designed to suit individual resident's needs. Community involvement was encouraged in the centre. Relatives and friends of residents were seen visiting during the day. Those who were spoken with by inspectors stated that they were always welcomed by staff and were complimentary of how residents were cared for. Overall there was a good standard of person-centred care in the centre. Inspectors reviewed a large number of HIQA questionnaires which had been sent out to residents and relatives prior to the inspection.

A number of improvements were required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. These included, fire safety management, governance and management, the use of CCTV in communal rooms, privacy and dignity issues, complaints management, safeguarding and safety, staffing issues, medication management and notifications.

An immediate action was issued to the provider on fire safety management in the centre. This was addressed under Outcome 8: Health and safety and risk management. The provider responded in a timely and responsive manner to the action plan and specified the actions which were attended to immediately.

**Compliance with Section 41(1)(c) of the Health Act 2007 and 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 Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***

***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors viewed the statement of purpose which described the service that was provided in the centre. It contained most of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. However, inspectors found that the information contained in the Certificate of Registration, the arrangements for the management of the centre in the absence of the person in charge, the arrangements for consultation with residents and a comprehensive protocol for the management of complaints were not contained in the Statement of Purpose as required by Regulations.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The quality of care and experience of residents reviewed on an ongoing basis. Sufficient resources were in place to ensure the delivery of quality care to residents. However, there had been no annual review of the quality and safety of care in the centre. In addition, the arrangements had not been completed for the management of the centre in the absence of the person in charge. This was addressed under Outcome 6: Absence of the person in charge. All appropriate training had not been provided, learning from audits had not been documented, staff appraisals were not yet done and all complaints were not accurately recorded. For example, issues of alleged abusive interactions were recorded as complaints. These issues were addressed under Outcome 18: Staffing and Outcome 13: Complaints.

**Judgment:**  
Non Compliant - Moderate

***Outcome 03: Information for residents***  
***A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**  
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
There was a Resident's Guide available to residents. It contained all the required information and a copy was seen in each resident's bedroom. In a sample of residents' files reviewed inspectors found that there was a written contract signed and agreed on admission. Each resident's contract outlined the care and services available in the centre. However, all the contracts did not specify the extra fees to be charged for example, hairdressing fees and bus outings. The provider stated that all contracts were currently being updated to ensure compliance with Regulations.

**Judgment:**  
Substantially Compliant

***Outcome 04: Suitable Person in Charge***  
***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**  
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**

The person in charge had recently been appointed in the centre. She was interviewed by inspectors. She was found to fulfil the regulatory criteria required for the post. The person in charge had been working as a nurse in the centre for the previous six years, included a period of time as assistant director of nursing. She was employed full time in the centre. The person in charge demonstrated clinical knowledge in ensuring suitable and safe care. She demonstrated knowledge of the legislation and of her statutory responsibilities. She was engaged in the governance, operational management and administration of this centre on a regular and consistent basis. She met regularly with the provider and staff. Minutes were maintained of these meetings. She organised audit in the centre. She explained to inspectors that she was engaged in continuous professional development and promoted continuous improvement in residents' care and staff access to relevant training.

**Judgment:**

Compliant

***Outcome 05: Documentation to be kept at a designated centre***  
***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Most of the records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained accurately and were easily accessible to inspectors. The designated centre was adequately insured against accidents or injury to residents, staff and visitors. Insurance certification was viewed by inspectors. The policies required under Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) were in place and were seen to be reviewed regularly. Complaints and incidents were documented.

A copy of the statement of purpose, the Resident's Guide and previous inspection reports were available to residents. However, the last medication incident was recorded in 2014: all medication errors had not been recorded. This was confirmed by the nurse who described errors when checking medicines on receipt from pharmacy. In addition,

on reviewing a sample of medication records inspectors noted two prescribing errors, which had not been noted or recorded by staff. Medication management issues were outlined in more detail under Outcome 9: Medication management. In addition, a comprehensive log was not maintained of bed rail checks and times of use.

**Judgment:**  
Substantially Compliant

***Outcome 06: Absence of the Person in charge***  
***The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

**Theme:**  
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
The provider/person in charge was aware of her statutory duty to inform the Chief Inspector of the proposed absence of the person in charge from the designed centre. However, arrangements were not completed to arrange for the management of the designated centre during his/her absence. Documentation had been sent to HIQA to appoint a new person participating in management (PPIM) to fulfil this role.

**Judgment:**  
Non Compliant - Moderate

***Outcome 07: Safeguarding and Safety***  
***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**  
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. Staff were trained on the policy. There were measures in place to safeguard residents and protect them from abuse. Staff spoken with by inspectors were



aware of the types of elder abuse and of what to do in the event of an allegation, suspicion or disclosure of an alleged incident. Residents spoken with informed inspectors that they felt safe and could report concerns to the person in charge or provider. However, a number of staff spoken with, including management staff, were not familiar with the Health Service Executive (HSE) 2014 policy on Safeguarding Vulnerable Persons at Risk of Abuse. In addition, a suitably qualified staff member had not provided the required training to all members of staff as the current facilitator had not been trained to deliver this specific knowledge to staff.

Bed rail use was reported to the Authority as required. However, a log of the use of bed rails was not maintained on a nightly basis. This was addressed under Outcome 5: Documentation. Appropriate risk assessments had been undertaken for residents.

Staff spoken with by inspectors had updated knowledge and skill in managing behaviours that challenge. A number of staff had yet to attend training in this area but were found to be knowledgeable of de-escalation techniques due to their induction training. Inspectors viewed documentation which indicated that this training was scheduled. Staff were seen to respect residents' privacy and dignity by knocking on bedroom doors prior to entry and to interact warmly with residents throughout the inspection.

Systems were in place to safeguard residents' money and this system was monitored by the provider, the person in charge and administration staff. This system included two staff members signing for any money lodged or withdrawn. A sample of records checked were seen to be in order. Residents had a locked storage space available for personal items. Some personal items were listed on residents' property lists as being stored in the safe. A number of these items were checked by inspectors and found to be correct.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

An immediate action plan on fire safety management in the centre was issued to the provider by inspectors. Areas of non compliance, with Regulation 28 on fire safety management, are set out under this Outcome.

A updated health and safety statement was in place and this specified the roles and responsibilities of staff. The risk management policy was reviewed and risk assessments carried out were specific to the centre and which mitigated risks to residents' safety.

However, the measures and actions to control abuse were not set out in the risk management policy. Controls were in place to prevent accidents such as falls. For example, inspectors observed that handrails were located on each corridor, grab-rails were located in toilet areas and that safe floor covering was in place. Copies of risk assessments were seen by inspectors. However, inspectors observed that a number of risks had not been assessed. For example: open access to the stairs both downstairs and upstairs, use of the lift, the care of a resident with behaviour issues which required one to one care, the use of wedges on designated fire safe doors and the presence of a significant infection for one resident. In addition, there was no health and safety committee in the centre and health and safety meetings were not held. This was set out as a requirement in the health and safety statement. The person in charge informed inspectors that health and safety issues were discussed at staff meetings.

The procedures in place for the prevention and control of infection were satisfactory. For example, hand gels were in place and hand washing facilities were easily accessible. Posters to guide staff and visitors on correct hand washing procedures were available and a contract was in place for the disposal of clinical waste. Arrangements were in place for responding to emergencies. A safe external location had been identified in the event of an emergency evacuation. The centre was seen to be very clean and there was a household staff member on duty who was dedicated to cleaning duties daily. She was found to be knowledgeable of infection control procedures and of the colour coded system in use for cleaning.

Suitable fire equipment was provided and there were adequate means of escape from the premises. Fire extinguishers were serviced on an annual basis and the procedure for the safe evacuation of residents and staff was prominently displayed. Annual fire safety training was undertaken for staff including fire evacuation training. However, inspectors found that records were not maintained of daily checks in relation to fire exits, of ensuring the alarm panel was working or of weekly testing of the fire alarm. In addition, the fire alarm panel and emergency lighting were not serviced on a three monthly basis. Furthermore, a number of fire doors were held open with wooden wedges on a number of occasions during the inspection, in the morning, in the afternoon and in the late evening. This practice continued throughout the inspection even though this was brought to the attention of the provider on day one of the inspection. The provider informed inspectors that regular fire drills were carried out. The previous fire drill was recorded as having been undertaken on 26 April 2016. However, a number of staff interviewed by inspectors were not sufficiently knowledgeable of the evacuation procedure. In addition, records of fire drills were not adequate. For example, the names of staff who attended were not recorded, the time of the drill was not specified and the outcome of the drill was not documented. One staff member explained that it had been a 'long time' since the training had been provided to her. Inspectors reviewed the fire safety training records. These indicated that twelve staff members had not been afforded mandatory fire training or had not attended a fire drill. The person in charge stated that this was discussed on induction. However, records of these induction procedures were not available in a sample of staff files checked.

Staff were trained in moving and handling of residents. Records viewed by inspectors confirmed this. Records were available which indicated that equipment was serviced when required.

**Judgment:**  
Non Compliant - Major

***Outcome 09: Medication Management***  
***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**  
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

The practice of checking, dispensing and recording of drugs administered was in line with current legislation. There was a single dose system in operation. Photographic identification for residents was present. Nurses spoken with demonstrated a clear understanding of their An Bord Altranais agus Cnaimhseachais na hEireann responsibility as regards medication management. Controlled drugs were checked by inspectors. The recording of these drugs was found to be correct. However, these drugs were not recorded and entered into a 'bound' register. Inspectors noted that they were recorded in a 'stapled' booklet, which is not in line with guidelines on safe medication management. The provider undertook to replace this book.

Medication management was the subject of audit by pharmacy on 1 February 2016. Medications were reviewed three monthly by the GPs and inspectors saw these records. There was a medication fridge in the centre and the temperature of this fridge was recorded. However, medication errors noted by inspectors included undated prescriptions, a faxed order which did not correlate with the prescribed dose of the drug on prescription and the maximum dose of PRN (when required) medication was not always stated. Furthermore, there was an unclear prescription for a resident: the frequency of administration on a prescription did not reflect the instructions on the medication administration sheet from the pharmacy for the medication. However, the nurse showed the inspector the new medication error book. He stated that he accepted the findings and he would actively address the issues identified by inspectors.

**Judgment:**  
Non Compliant - Moderate

***Outcome 10: Notification of Incidents***  
***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**

Safe care and support
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> A record was maintained of incidents occurring in the centre. Quarterly notifications were submitted as required. However, inspectors noted that incidents of alleged abusive interaction were not notified to HIQA as required, but were recorded as complaints. These were sent in to HIQA retrospectively along with follow up reports.</p>
<p><b>Judgment:</b> Non Compliant - Moderate</p>

***Outcome 11: Health and Social Care Needs***  
*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**  
Effective care and support

<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> Residents had access to regular GP and pharmacy services. Medication was reviewed by GPs on a three-monthly basis. Specialist services and allied health care services such as occupational therapy were available by referral. Speech and language, dietician, optician, dental and physiotherapy services were seen to have been availed of by residents. Chiropody and hairdressing services were accessed on a private basis within the nursing home. Records were maintained of referrals and follow-up appointments to consultants or allied health services. Clinical assessments such as falls assessment, nutrition assessment, skin assessment and cognitive assessment were completed. Residents' right to refuse treatment was respected and documented.</p> <p>A comprehensive assessment of residents' health and social care needs took place prior to admission. Appropriate care plans were seen to be in place which were reviewed four monthly. Residents, and their representatives where appropriate, were involved in formulating care plans. Residents' signatures were seen on consent forms within the care plan and on their contracts of care. However, inspectors noted that a number of care plans in residents files had not been completed and in addition, some care plans</p>
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were generic in nature. For example, a number of care plans formulated for specific medical issues were blank or did not clearly set out which treatment, from a choice of various treatments listed on the form, which were to be provided to the resident involved. In addition, there were a number of different files used to record residents' daily care. Inspectors observed that this practice led to incorrect information in residents' personal plan folders. For example, there was documentation seen in one folder which indicated that a resident had a pressure sore for which he was receiving pain relief. However, a second file for the same resident indicated that this wound was now healed. In addition, one resident in the centre required 12 hour monitoring during the night. A care staff member was assigned to this duty each night. Inspectors found that the documentation recorded for this resident was brief and inadequate. There was no care plan in place to guide staff on his night time routine and the care required. In a sample of night reports seen the nurse had made a brief record of "breathing normally" on the night report of this person, who had complex needs. This was discussed with the person in charge who stated that a more comprehensive record would be maintained of the resident's night time needs and behaviour. A senior nurse informed inspectors that staff were working on producing person centred care planning documentation. A sample of these were seen and were found to be person focused. End of life care planning issues were discussed under Outcome 14: End of life care.

Life story information was used to inform the activity programme and the daily preferred routine of each resident. Access to radio, favourite programmes and daily newspapers were also facilitated. One resident informed inspectors that she was a fan of 'Fair City' and staff were heard to discuss events from the latest episode with her. Additional activities and opportunities to socialise were discussed under Outcome 16: Residents' rights dignity and consultation.

Residents were supported to maintain their independence. There was an emphasis on promoting health and residents' general well being. All residents were encouraged to participate in the social life of the centre. On the afternoon of inspection a physiotherapist was present with residents. Residents informed inspectors that this was a weekly occurrence. Residents participated in chair based exercises with the physiotherapist and passive exercises were also carried out. In addition, a therapist was present during the morning to provide individual hand and foot massage for residents. Inspectors spoke with the therapist who explained the benefit of the therapy and the individual attention each resident received during the interaction.

**Judgment:**

Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Effective care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The centre was purpose built by the provider over a period of four years. The design and layout of the centre promoted residents' independence and wellbeing. Storage facilities were generally adequate. There was a functioning call bell system in place and there was suitable storage in place for residents' belongings. The provider maintained a safe environment for residents' mobility with handrails in circulation areas and suitable floor covering. The decoration throughout was of a good standard and an ongoing redecoration programme was in place. Adequate space was available to support residents' privacy. There was a variety of communal space available, including a room which was set up for those residents who smoked. At the time of inspection the centre appeared warm and comfortable.

The premises and grounds were well-maintained. The size and layout of bedrooms was suitable to meet the needs of residents. Each single and double bedroom had an en suite facility. The centre had 28 single en suite bedrooms, eight double en suite bedrooms and two double rooms, which had toilet and shower facilities adjacent to the rooms. There were three sitting rooms in addition to the aforementioned smokers' room, a dining room, a separate kitchen and an oratory in the centre. Equipment was well maintained and service records were available to inspectors. Storage arrangements for equipment was generally safe, however, this was limited. For example, hoists, commodes and some large chairs were stored in a number of the bath/shower rooms and in the oratory. There were at least ten wheelchairs stored in the oratory during the two days of inspection as well as two chairs which were awaiting repair.

Residents were generally positive in their comments in relation to the laundry arrangements and the linen cupboards were seen by inspectors to be well stocked. Residents' wardrobes were noted to be tidy. Personal items were displayed around the home as well as in residents' bedrooms.

There were spacious, well maintained gardens in the centre. The gardens were easily viewed through the large picture windows and residents spoken with expressed that they enjoyed the view. They spoke with inspectors about time spent in the gardens the previous year.

**Judgment:**

Substantially Compliant

***Outcome 13: Complaints procedures***

***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Policies and procedures were in place for the management of complaints. However, this required updating as the name of the previous person in charge, who was referred to as the complaints officer, was still on the policy. In addition, the complaints process was displayed high on the wall in a position that was not accessible to residents.

Furthermore, it was unclear as to the identity of the person nominated to oversee the management of complaints in the centre, as required by Regulations and the appeals process was not clearly outlined. For example: contact details for the ombudsman were not included.

Records of complaints were reviewed by inspectors. These were recorded comprehensively and residents stated that they felt enabled to make a complaint. However, the satisfaction or not of each complainant had not been documented. Inspectors found that a number of complaints concerning allegations of unsatisfactory staff interactions were recorded in the complaints book and had not been notified to HIQA as allegations of alleged abuse of residents. The response to these complaints did not specify if action had been taken to satisfy the complainant and to prevent a recurrence of the event. In addition, additional staff training had not been provided, where appropriate, on safeguarding and protection of residents. In a sample of residents' files reviewed inspectors observed that a complaint had been documented by the night staff in the resident's file and not in the complaints book. This was brought to the attention of the person in charge.

**Judgment:**

Non Compliant - Moderate

***Outcome 14: End of Life Care***

***Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

There were written operational policies and protocols in place for end-of-life care in the centre. Staff, with whom the inspector spoke, were knowledgeable about how to support residents and families at the end-of-life stage. The policy offered guidance for

staff in caring for the holistic needs of residents.

A comfortable sitting room was available for family and friends to use as an overnight facility in the event that a resident was unwell. Facilities were provided for relatives to have refreshments and snacks. Open visiting was facilitated at the end-of-life stage. A single room could be availed of for a resident if this was necessary or if this was requested.

The person in charge stated that specialist palliative care services had been availed of. Following the previous thematic inspection the person in charge had commenced documenting residents' wishes in the 'Advanced Care Plan' which had been developed for the centre. Inspectors saw evidence in a number care plans that discussions on advanced care planning had been held with some residents. However, a number of these plans were blank, even though the results of an audit had indicated that 100% of residents had end of life care plans in place.

Inspectors spoke with some relatives who expressed that they found the staff to be very supportive of residents and that they could discuss concerns with the provider and person in charge. There was a memorial service held annually for deceased residents. Clothing inventories were maintained and the centre had a specific protocol for the return of residents' clothing to the family. The centre packed the clothing in a specific bag which had the logo of the centre on it.

**Judgment:**

Substantially Compliant

***Outcome 15: Food and Nutrition***

***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

Recently reviewed policies for the assessment, monitoring and documentation of residents' nutritional and fluid requirements were in place. All meals were freshly prepared on site in the well equipped kitchen. Inspectors saw that there were adequate stocks of fresh, frozen, home baked and dry food supplies and the service was monitored by the relevant environmental health officer (EHO); these inspection reports were available for review. Inspectors observed that 24 residents were present in the main central dining room for dinner. Staff informed inspectors that a number of residents, by choice or due to their dependency needs, remained in their rooms for meals. A number of residents spoken with by inspectors confirmed that they preferred



to dine in their room or in the sitting room. Inspectors were satisfied as to the quality of the dining experience in both locations. An adequate staffing presence was maintained during meal times and assistance was provided in a discreet and unhurried manner. Meals including meals required in a modified format were presented in an appealing manner in accordance with each resident's requirements.

A daily menu offering choice was prominently displayed; staff and residents reported that meal preferences were established daily and/or at each mealtime and these documents were reviewed by inspectors. Feedback from residents on the quality and variety of the meals provided was evident in the minutes of residents' meetings. Actions taken and the response to any feedback received was recorded.

Procedures were in place for the management of residents' specific nutritional requirements. Staff had received training on areas such as dysphagia (difficulty in swallowing), nutritional assessments and the completion of nutritional care plans. Staff completed oral assessments and the malnutrition universal screening tool (MUST) was used to assess the risk of malnutrition. Where a problem was identified the appropriate care plan was in place. Staff weighed residents on a monthly basis and intervened with specialist support where appropriate. There was documentary evidence of medical, dietician and speech and language therapy review and these recommendations were incorporated into the relevant care plans. There were formal systems of communication between clinical and catering staff and inspectors formed the view that communication was effective, based on the knowledge of staff members spoken with on inspection.

**Judgment:**  
Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***  
***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**  
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
There were opportunities for residents to participate in activities which suited their needs, interests and capacities. For example, residents with cognitive impairment were provided with reminiscence therapy, old movies and one to one activity. Residents with restricted mobility had access to music, singing session, chair based exercises, DVDs and art work. Residents who enjoyed keeping up-to-date with current affairs were provided with daily newspapers and access to TV. Afternoon tea parties were held six weekly and

'china' cups were used to provide a reminiscence opportunity for residents. Residents were consulted with and participated in the organisation of the centre. Minutes of residents' meetings were maintained and these were held three monthly. Each resident's privacy and dignity was respected, including receiving visitors in private. They were facilitated to communicate effectively and exercised choice and control over their lives.

There were a number of photographs on display in the centre which indicated that there were parties and special occasions celebrated throughout the year. In addition, there were photographs on display of visiting musicians, choirs and school groups. Minutes of residents' meetings indicated that activities such as, art, bingo, playing cards, music, dancing, singing, mass, cinema nights, massage, physiotherapy exercises and parties were part of weekly life in the centre. Visitors were plentiful and residents were seen to go out to visit family and to attend appointments. Residents and relatives with whom inspectors spoke confirmed these events and that they had access to a varied activity programme. There was an activities coordinator available on a daily basis and two volunteers attended the centre twice a week. The person in charge informed inspectors that these ladies were former staff members.

Residents had access to advocacy services through the volunteer presence. The provider had also made contact with an independent advocacy service of behalf of some residents. Routines and practices promoted residents' independence. They were facilitated to exercise their civil, political and religious rights and were enabled to make informed decisions about the management of their care. Residents spoke knowledgeably about events locally and nationally. Residents' religious rights were supported through regular visits by the clergy and the provision of appropriate religious services.

However, garden access was limited at certain times of the years according to staff. Inspectors noted on the day of inspection that a number of access doors to the garden were locked. Inspectors viewed minutes of residents' meeting which documented accounts of residents enjoying time in the garden at barbeques and garden parties. The person in charge stated that she would improve signage re accessibility to the gardens. In addition, one bathroom was located next to the 'mens' sitting room. This had not been assessed as to the impact on the privacy and dignity of residents who showered or had a bath in this bathroom in the morning. Inspectors noted that there were a number of closed circuit TV (CCTV) cameras located in the centre. These were present in the hallways, smoking room and the three communal rooms. There was a CCTV policy in place and there was signage in place indicating the use of a CCTV camera in each area of use. The provider was asked by inspectors to ensure that data protection law was not breached by the installation of CCTV in communal rooms as regards, residents', relatives', visitors' and staff rights. The provider undertook to review this arrangement in line with current data protection guidelines.

**Judgment:**

Substantially Compliant

***Outcome 17: Residents' clothing and personal property and possessions  
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of***

<b><i>clothes to residents.</i></b>
<p><b>Theme:</b> Person-centred care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> Residents maintained control over their personal property and possessions. Inspectors viewed the policy on personal possessions and clothing. There were adequate laundry facilities in place to ensure that residents' personal clothing was laundered and safely returned to them. Bed linen was laundered externally and adequate clean supplies were stored in the linen cupboard. Personal clothing was washed at home by residents' representatives in the case of a small number of residents. There was adequate space for each resident to store and maintain his/her own clothes and other possessions.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b><i>Outcome 18: Suitable Staffing</i></b> <b><i>There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.</i></b></p>
<p><b>Theme:</b> Workforce</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> There were appropriate staff numbers and skill mix to meet the assessed needs of residents. There were adequate staff numbers on duty for the size and layout of the designated centre, according to the roster viewed by inspectors. The majority of staff had up-to-date mandatory training. They also had access to a range of training to meet the needs of residents, for example training in dementia care issues, manual handling, health and safety, care issues and food hygiene. Staff with whom inspectors spoke confirmed their knowledge of this training. All staff and volunteers were supervised on an appropriate basis and recruited, selected and vetted in accordance with the centre's policy. However a number of staff had not received mandatory fire training. This was</p>

addressed under Outcome 8: Health and Safety

A sample of staff and volunteer files viewed by inspectors were not all in compliance with the requirements of Regulations. For examples, staff appraisals had not taken place, induction records were not maintained, volunteers in the centre did not have their roles and responsibilities set out. The volunteers who were previous employees had Garda vetting in place. However, this had not been updated since 2009 and was required to be updated for the new role of volunteer. All relevant care staff had undertaken Fetac level 5 training in care of the older adult. The personal identification numbers of staff nurses in the centre were maintained.

**Judgment:**  
Non Compliant - Moderate

### Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

#### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

#### ***Report Compiled by:***

Mary O'Mahony  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Lystoll Lodge Nursing Home
<b>Centre ID:</b>	OSV-0000246
<b>Date of inspection:</b>	11/05/2016
<b>Date of response:</b>	03/08/2016

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 01: Statement of Purpose

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The statement of purpose reviewed by inspectors did not contain all the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

For example:

- the information contained in the Certificate of Registration
- the arrangements for the management of the centre in the absence of the person in

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

charge

- the arrangements for consultation with residents
- a comprehensive arrangement for the management of complaints

**1. Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Please state the actions you have taken or are planning to take:**

The statement of purpose has been updated.

**Proposed Timescale:** 03/08/2016

**Outcome 02: Governance and Management**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Effective management systems were not in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored,

For example:

- the actions, learning and improvements from audits were not documented
- complaints and incidents had not been subject to audit.

**2. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**

The home has now introduced a new Quality Management System. (QMS) The QMS requires that all adverse actions/processes/findings are recorded on. A Corrective Action Request (CAR) which alerts the PiC to the need to bring the adverse issue to a Quality Improvement Meeting (QIM) for review and analysis using the Root Cause Analysis Tool. (RCA) The QMS manages the auditing of the centre and the consequential learning and improvements and also the complaints and incidents audits. A system has been put in place in the QMS for an Annual review of quality and improvements.

**Proposed Timescale:** 31/10/2016

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The registered provider failed to ensure that there was an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care was in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

**3. Action Required:**

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

**Please state the actions you have taken or are planning to take:**

The Annual Review of Quality is now being managed by the QMS and the first report will be generated by the end of 2016 when sufficient data is collected.

**Proposed Timescale:** 31/12/2016

**Outcome 03: Information for residents**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Details of all fees to be charged to residents were not included in a sample of contracts reviewed by inspectors.

**4. Action Required:**

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

**Please state the actions you have taken or are planning to take:**

All contracts are now amended to show all fees.

**Proposed Timescale:** 03/08/2016

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Medication errors were not recorded and these were not available to inspectors.

A comprehensive log of checks of bed rail use at night had not been maintained.

**5. Action Required:**

Under Regulation 21(1) you are required to: 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.

**Please state the actions you have taken or are planning to take:**

- a) Medication errors are now all being recorded by the QMS through the CAR system for RCA at the QIM
- b) A new format of bed rail checks has been put in place and is being maintained

**Proposed Timescale:** 31/08/2016

**Outcome 06: Absence of the Person in charge**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The provider had not made provision for a suitably qualified person to be available to act in the position of the person in charge.

**6. Action Required:**

Under Regulation 33(2)(c) you are required to: Give notice in writing to the Chief Inspector of the name, contact details and qualifications of the person who will be or was responsible for the designated centre during the absence of the person in charge.

**Please state the actions you have taken or are planning to take:**

An assistant PIC has now been appointed and the appropriate documentation has been sent to HIQA

**Proposed Timescale:** 03/08/2016

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staff and management staff had not received training in the 2014 HSE policy on Safeguarding and Protection of Vulnerable Older Adults.

All staff members were not trained by a suitably facilitator who had been trained to deliver this training.



**7. Action Required:**

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**

Training for all staff has been completed and evidence has been sent to hiqa

**Proposed Timescale:** 03/08/2016

### Outcome 08: Health and Safety and Risk Management

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy did not set out the measures and actions in place to control abuse.

**8. Action Required:**

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

**Please state the actions you have taken or are planning to take:**

An extensive and robust Policy and procedure is in place dealing with abuse . This is clearly referenced from the section dealing with abuse in the Risk Management Procedure.

**Proposed Timescale:** 03/08/2016

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

All risks in the centre had not been assessed and controls had not been set out for these.

For example;

- the open access to the stairs both downstairs and upstairs
- use of the lift
- the care of a resident with behaviour issues which required one to one care
- the use of wedges on designated fire safe doors
- the presence of a significant infection.

**9. Action Required:**

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy

set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**

- a) Risk assessment will be carried out on the stairs both downstairs and upstairs
- b) Risk assessment will be carried out on the use of the lift
- c) A policy on one to one care has been created as an annex to our Risk Management Policy and Procedure following a risk assessment of the identified resident.
- d) Doorgaurd door closers have now been fitted to all doors
- e) Infection risks are now more comprehensive in our Infection Control Policy and Procedure and in our Residents Risk Register.

**Proposed Timescale:** 31/08/2016

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Emergency lighting and the fire safety panel was not maintained on a three monthly basis.

**10. Action Required:**

Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

**Please state the actions you have taken or are planning to take:**

The fire safety panel and emergency lighting has been tested and evidence forwarded to Hiqa. Both will be maintained on 3 monthly basis in future.

**Proposed Timescale:** 03/08/2016

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Designated fire safe doors had not been fitted with suitable opening mechanism. A number of these were held open by wooden door wedges.

**11. Action Required:**

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**

Doorgaurd door closers have now been fitted to all doors and evidence of this has been sent to Hiqa.

**Proposed Timescale:** 03/08/2016

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

All staff in the centre had not been afforded fire training.

A number of staff interviewed were not sufficiently knowledgeable of fire evacuation procedures.

Records were not maintained of those staff who had attended fire drills during the year.

**12. Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

**Please state the actions you have taken or are planning to take:**

a) All Staff have completed training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

b) A record of staff who attend any future fire drills will be maintained correctly in the fire register

**Proposed Timescale:** 03/08/2016

**Outcome 09: Medication Management**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Issues identified in medication management included:

-undated prescriptions

-a faxed order which did not correlate with the prescribed dose of the drug on prescription

-the maximum dose of PRN (when required) medication was not always stated

-there was an unclear prescription for a resident: the frequency of administration on a prescription did not reflect the instructions on the medication administration sheet from the pharmacy for the medication.

**13. Action Required:**

Under Regulation 29(5) you are required to: 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.

**Please state the actions you have taken or are planning to take:**

A new medication Policy and Procedure has now been put in place which clearly requires that all medicinal products are administered in accordance with the directions of the prescriber. Further the medication Policy and Procedure is overseen by the QMS through regular audits and the use of CARs and the QIM.

**Proposed Timescale:** 03/08/2016

**Outcome 10: Notification of Incidents**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Allegations of alleged abusive interaction had not been reported to HIQA.

**14. Action Required:**

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

**Please state the actions you have taken or are planning to take:**

All notifications have since been sent to Hiqa. We did not recognise the allegation made as notifiable incidents; we have learned from this and will ensure that it is documented correctly and that Hiqa are notified within the correct timeframe of any future confirmed or alleged incidents.

**Proposed Timescale:** 03/08/2016

**Outcome 11: Health and Social Care Needs**

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Care plans were not in place for some residents.

A number of care plans were generic in nature and did not support individualised care.

A specific night time care plan was not in place for a resident who required one to one care at this time.

**15. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

**Please state the actions you have taken or are planning to take:**

All residents will have care Plans as set out in the Integrated Clinical File.

Care plans will no longer be generic, they will be person centred and managed by a named nurse.

A specific night time care plan will be put in place for a resident who required one to one care.

**Proposed Timescale:** 31/10/2016

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Discrepancies were noted in the information recorded in some care plans which indicated to inspectors that all plans were not being reviewed when required. For example:

-a wound care plan had not been updated

-the visit of the speech and language therapist had not been recorded in the nutrition care plan of a resident.

**16. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

**Please state the actions you have taken or are planning to take:**

A new Procedure on wound Care is in place including a template Care Plan which will provide for a consistent and competent method of personalised care planning.

**Proposed Timescale:** 03/08/2016

**Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Storage space for chairs and equipment was limited.

The oratory was used as a store room and hairdressing facility.

**17. Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**

Storage space is being reviewed eg. A building next door is being used for storage.

**Proposed Timescale:** 03/08/2016

**Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The complaints procedure was not accessible to residents and their representatives.

**18. Action Required:**

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**

The complaints procedure is compliant with the Health Act 2007 and the National Standards 2016 and includes an appeals procedure

A copy of the procedure will be provided to all residents/ relatives.

**Proposed Timescale:** 20/10/2017

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A copy of the complaints procedure was not displayed in a prominent place.

**19. Action Required:**

Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**

The Complaints procedure has been lowered to eye level on the wall in the foyer

**Proposed Timescale:** 03/08/2016

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

All complaints received had not been investigated robustly.

**20. Action Required:**

Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.

**Please state the actions you have taken or are planning to take:**

A new Complaints Policy and Procedure is now in place. This sets out the pathway to a robust investigation and guides the resident through each stage to the final appeal to the ombudsman.

**Proposed Timescale:** 03/08/2016

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all records of complaints were recorded in the complaints book.

**21. Action Required:**

Under Regulation 34(1)(f) you are required to: 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.

**Please state the actions you have taken or are planning to take:**

All complaints will now be logged either in the nurses notes in the case of minor issues and in the Complaints Book in the case of more serious issues. All complaints in the complaints book are referred to the QIM for review and analysis. Training of staff will take place and audits will be conducted of the complaints process.

**Proposed Timescale:** 03/08/2016

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Measures required for improvement in response to a complaint had not been put in place.

**22. Action Required:**

Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

**Please state the actions you have taken or are planning to take:**

All complaints logged in the Complaints Book will be review and analysed at the QIM for the purpose of learning and continuous improvement. A record is maintained of this process.

**Proposed Timescale:** 30/10/2016

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A person had not been nominated, other than the person nominated in Regulation 34 (1)(c), to be available in the designated centre to ensure that all complaints were appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintained the records specified under in Regulation 34 (1)(f).

**23. Action Required:**

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

**Please state the actions you have taken or are planning to take:**

Our new Policy and Procedure is based on the Health Act 2007 SI 415 and the National Standards for Residential Care Setting in Ireland 2016.

**Proposed Timescale:** 03/08/2016

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

It was not clear from documentation reviewed that all residents had been consulted with on the outcome of their complaint and that the appeals process had been outlined to them where they were not satisfied.

**24. Action Required:**

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

**Please state the actions you have taken or are planning to take:**



The Policy and Procedure now in place clearly requires feedback to the resident following an investigation and clearly sets out the appeals process.

**Proposed Timescale:** 03/08/2016

#### **Outcome 14: End of Life Care**

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

All residents' wishes had yet to be documented as regards end of life care.

**25. Action Required:**

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

**Please state the actions you have taken or are planning to take:**

All End of Life care plans are being reviewed and the residents wishes will be included in all the reviewed care plans.

**Proposed Timescale:** 31/10/2016

#### **Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Access to the garden was not facilitated on a regular basis.

**26. Action Required:**

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**

There is access to the garden through the double doors in the main front corridor, and although the doors are alarmed for safety purposes, if residents wish to go out to the garden they are free to do so, and residents are aware of this. These doors are push bar protected but can be opened easily. However we will put signage up to identify the exit in order to make it clearer to our residents that they can access the garden when they choose.

**Proposed Timescale: 03/08/2016**

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

One bathroom was located adjacent to the 'mens' sitting room. Measures had not been put in place to ensure that the privacy and dignity of residents, who showed or bathed in this room, was protected.

**27. Action Required:**

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**

To ensure that our residents are not seen going into the bathroom in the morning a mobile screen will be erected between the sitting room and the bathroom during the morning.

**Proposed Timescale: 31/07/2016**

### **Outcome 18: Suitable Staffing**

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff appraisals and supervision had yet to commence on a formal basis.

**28. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**

Staff appraisals have commenced and all formal supervision is recorded on the new Supervision Sheet.

**Proposed Timescale: 30/09/2016**

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The roles and responsibilities of people involved on a voluntary basis with the designated centre were not set out in writing.

**29. Action Required:**

Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

**Please state the actions you have taken or are planning to take:**

Roles and responsibilities for our volunteers is now set out in writing

**Proposed Timescale: 03/08/2016**

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Updated Garda Vetting had not been obtained for volunteers.

**30. Action Required:**

Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

**Please state the actions you have taken or are planning to take:**

Updated Garda vetting has been applied for the volunteers.

**Proposed Timescale: 03/08/2016**