Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Lystoll Lodge Nursing Home
Name of provider:	Lystoll Lodge Nursing Home Limited
Address of centre:	Skehenerin, Listowel, Kerry
Type of inspection:	Unannounced
Date of inspection:	07 and 08 November 2018
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0024922

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Lystoll Lodge Nursing Home is situated in the countryside in peaceful surroundings approx one mile outside the heritage town of Listowel. The Nursing Home is serviced by nearby restaurants/ public houses/ libraries/ heritage centre and various shops. 24-hour nursing care is available which is led by the person in charge, who is a qualified nurse. Staff participate in regular training courses to maintain and improve the level of care for residents. Lystoll Lodge Nursing Home employs 50 staff. All staff and visiting therapists have the required Garda Vetted (GV) clearance in place. Accommodation is available for both male and female residents requiring continuing care, respite care, convalescence care, dementia care, psychiatric care and end-of-life care. Admissions to Lystoll Lodge Nursing Home are arranged by appointment following a pre-admission assessment of needs. This is to ensure that the centre has all the necessary equipment, knowledge and competency to meet residents' needs. On admission all social activities/hobbies, leisure interests and local amenities available to residents, are discussed. For example, local social events such as Listowel races and Listowel writers' week can be accessed. A care plan will be developed with the resident's participation within 48 hours of admission. This will be individualised for personal care needs and will provide direction to staff members. All food is prepared freshly and cooked by the chefs who tailor meals to meet the preferences and requirements of residents.
Residents meet on a quarterly basis to discuss any improvement or changes that they would like to see in the operation of the centre. An open visiting policy operates within Lystoll Lodge Nursing Home. Complaints will be addressed and the complaints policy is set out in the statement of purpose.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
07 November 2018	11:00hrs to 19:15hrs	Mary O'Mahony	Lead
08 November 2018	09:00hrs to 17:40hrs	Mary O'Mahony	Lead
07 November 2018	11:00hrs to 19:15hrs	John Greaney	Support
08 November 2018	09:00hrs to 17:40hrs	John Greaney	Support

Views of people who use the service

Residents told inspectors that they were happy with the staff and their accommodation. They said that they were facilitated to exercise choice in their daily lives. For example, they had choice at each meal, bedtime and type of activity. Residents spoke with inspectors about local events which they had attended especially Listowel races. All residents were encouraged to participate in the social life of the centre. Residents stated that they enjoyed a range of activities which were organised and led by the activity coordinator. Residents said that the weekly physiotherapy sessions were very popular as it gave them a sense of general well-being and of social interaction. Residents said that they also enjoyed regular music sessions, art classes, exercises and bingo.

Residents informed inspectors that the location of the centre was very convenient for their visitors. They were glad to be near the local town. They enjoyed scenic views over the hills and mountains. The building was set in well-maintained gardens. Mobile residents said that they had independent access to outdoor walks independently or with support from staff. Residents were also encouraged to go out with family members to their houses or the local restaurants and shops.

Capacity and capability

This inspection was carried out as part of a regulatory plan for Lystoll Nursing Home in accordance with the escalation policy of the Authority. Following findings on the previous inspection in April 2018 the provider had been asked to attend a meeting at the office of the Chief Inspector. At this meeting the provider was informed of the consequences of repeated non-compliance up to and including the placing of conditions on the registration of the centre. Similar to findings on the previous inspection in April 2018 a number of risks identified under the Quality and Safety dimension of this report indicated that the management system had failed to identify significant gaps in records, in risk identification or in the maintenance of the fire safety system to ensure that the service provided was safe, appropriate and consistently monitored. For these reasons inspectors remained concerned that the registered provider had failed to set out a clearly defined management structure which identified areas of authority and accountability, specified responsibilities for the various roles and had failed to adequately follow up on actions to be taken following the last inspection. Subsequent to findings on this inspection the provider was again required to attend the office of the Chief Inspector to discuss the findings of non-compliance. Two urgent action plans and two immediate action plans were issued on this inspection.

On the previous inspection improved quality management measures such as management meetings and audits had been set up. These had been continued under the leadership of the person in charge and the deputy person in charge. Audits had been undertaken in areas such as falls, medication management and the use of restraint. However, the system required review as it had failed to identify omissions in documentation, such as staff files, notifications and the continuing medication errors.

The protocol for complaints management was displayed at the entrance to the sitting room. This still lacked clarity as to the identification of the appeals person and there were inconsistencies noted between the policy, the displayed guidelines and the information in the statement of purpose in relation to the appeals process. This was a repeat non-compliance.

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

Copies of the standards and regulations were available and accessible to staff. Maintenance records were in place for equipment such as hoists and fire safety equipment. Most of the records and documentation as required by Schedule 2, 3 and 4 of the Regulations were maintained and easily retrievable. Residents' records such as care plans, assessments, medical notes and nursing records were, on the whole, detailed and relevant.

A sample of staff files was reviewed. Inspectors found that four staff members recently employed in the centre did not have required An Garda Síochána vetting (GV) clearance in place. An urgent action plan was issued to the provider for which a satisfactory response was received within the time frame set by the Chief Inspector. Following findings on the previous inspection staffing had been augmented at night time and there were now two staff nurses and two care assistants available throughout the night to attend to residents' needs. Staff and residents stated that this was an improvement as regards receiving timely attention. On this inspection inspectors found that there was inadequate supervision of pre-registration nurses. Inspectors noted that these staff were signing for the administration of medications contrary to the guidelines set out by an Bord Altranais: where two signatures are required in such situations and medicines are only to be administered under the supervision of a registered nurse.

The staff roster was incomplete with a number of staff members not included on the

roster. This meant that inspectors were unable to verify the full complement of staff proposed to be on duty during the two days of inspection. The minutes of the most recent staff meeting were not dated. For this reason it was difficult to ascertain if they were the minutes of the most recent meeting. Staff informed inspectors that staff meetings were infrequent and that the last staff and nurse meeting was held in April 2018. Weekly management team meetings did not include the full senior management team. There was a high turnover of staff in the centre with 17 staff reported to have left this year. Two of these staff were reported to have been 'summer' workers and one staff was reported to have left to pursue nurse training. This lack of consistency was disconcerting for residents and relatives as they had built a relationship with these staff. The provider representative stated that other staff members had been in the centre for a number of years however.

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the regulations, She was seen to be engaged in consultation with residents and to attend handover reports with staff. She carried out a large number of audits, organised the quality management meetings and reviewed care plans.

Judgment: Compliant

Regulation 15: Staffing

Inspectors were unable to verify the full staffing complement as not all staff were on the roster.

Judgment: Not compliant

Regulation 16: Training and staff development

Inadequate supervision was available for pre-registration nurses.

Not all mandatory training had been provided.

Staff training in infection control was inadequate.

Judgment: Not compliant

Regulation 21: Records

Records of fire drills and fire training were not maintained in such a way as to assure inspectors that all staff had received the required training.

Resident records were not secured stored.

The staff roster was not complete as all staff were not included on this, namely the cleaning staff, laundry staff, activity staff and the kitchen staff.

Four staff, three of which were on duty during the inspection did not have the required Garda Siochana (Police) vetting (GV) in place.

Not all staff had the required two references on file. Not all CVs (curriculum vitae) were complete.

Judgment: Not compliant

Regulation 23: Governance and management

Maintenance, repairs and the provision of suitable equipment, such as fire safety and evacuation equipment required review.

The system in place to provide for a service which was safe, appropriate, consistent and effectively monitored was not adequate or robust.

Staff meetings were infrequent.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of contracts reviewed did not set out the room number of residents and the number of occupants of the room as required by a 2016 amendment to the regulations.

Judgment: Not compliant

Regulation 3: Statement of purpose

The complaints management guidelines in the statement of purpose was not correlated with the information displayed in the public notice. This had the potential to lead to confusion or ambiguity for any person who wished to make a concern or complaint known to the relevant party.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications on the outbreak of an infection had not been submitted to the Chief Inspector.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The appeals process was not clearly set out.

One complaint seen in the resident's care plan had not been properly documented in the complaints book.

It was not clear if all complainants were satisfied. One person had sent in a detailed complaint about lack of care, the coldness of the centre, and having to repair a handrail himself. The resident had been taken home and allegedly diagnosed with pneumonia and the public health nurse had contacted the centre. There had been no further communication with the complainant even though the complaint was marked as "complainant satisfied"

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The medication policy, the infection control policy and the fire safety policy were not adopted and implemented.

Judgment: Substantially compliant

Quality and safety

Inspectors found that there was an improvement in resident supervision particularly in the upstairs sitting room and bedrooms. A staff nurse had been stationed in the upstairs department where 30 residents resided and activity provision was seen to be available to residents at various times during the day. A desk and cupboard had been placed at the top of the stairs in a small alcove area. Inspectors found that the cupboard which held 30 personal files for residents was unlocked throughout the days of inspection. This presented a risk of a potential data protection breach particularly in view of its location in such a public area.

Residents had comfortable, spacious accommodation. Bedrooms were single or double rooms with en suite showers and toilets. Since the previous inspection a number of furniture and ceiling repairs had been completed and the decor was nice and bright. Inspectors found, however, that paint on woodwork was damaged and scuffed in a number of doorways and halls. Opportunities for social engagement were provided to groups of residents and they were particularly engaged in the music and singing sessions. During the inspection activities such as bingo, newspaper reading, reminiscence and physiotherapy were seen to be available. Residents were also seen in the communal sitting areas watching TV, meeting with visitors or talking with staff. Activity involvement was documented on a daily basis. Residents looked relaxed in the presence of staff who appeared to be very familiar with their backgrounds and preferences.

Inspectors found that residents' healthcare and nursing needs were met to a good standard. Care plans were individualised. General practitioners (GPs) attended the centre regularly. Allied health services were accessible. Clinical assessments took place using evidence-based tools, such as the MUST (Malnutrition Universal Risk Management) tool, and care plans had been updated. An occupational therapist (OT) had assessed residents for suitable seating and lap-belts were no longer in use. This meant that the risk of accidents to residents had been reduced and the relevant residents were enabled to sit out out of bed in comfort. Not all care plans had been developed for residents with specific needs.

Arrangements were in place in relation to accessing pharmacy services. A significant concern remained in relation to the absence of the signatures of some nurses who checked or administered the controlled drugs. Signatures were not available for all such transactions, similar to findings on the previous inspection. This was in contravention of the guidelines set out for nurses in An Bord Altranais, ''Guidance to Nurses and Midwives on Medication Management'' 2007 and of the guidelines in the centre's own policy on medicines management. Increased supervision, improved training and a comprehensive audit of controlled drugs had failed to adequately reduce the risk presented by this practice to ensure the safety of residents and the safe provision of this important medication. This was a repeat non-compliance and a similar issue had formed part of a serious concern previously notified to the Office of the Chief Inspector. This poor practice had the potential for a serious error. In

addition, discrepancies were noted in the duplication of signing times and days and not all drugs were transcribed properly. For example, 'paracetamol' was transcribed in the drug administration sheet without a dosage or times of administration for the resident involved.

On this inspection, inspectors reviewed the risk register and found that there were some risks which had not been assessed or updated. A number of these related to potential fire safety risks related to the smokers' room fire safe door, the safe storage of oxygen and the ongoing medication recording omissions. Daily, weekly, three-monthly and other required checks of the fire safety system were carried out, including checks of the fire-safe doors and fire extinguishers. These checks had failed to identify the numerous deficiencies in the fire safe doors as set out below. While a personal evacuation plan (PEEPs) had been developed and had been located within residents' wardrobes, not all these documents reviewed contained personal identification information. This had the potential to increase risk in the event of a fire requiring evacuation of residents as staff had to rely on the information to evaluate the mode of evacuation for each resident. In addition, certificates related to the quarterly servicing of emergency lighting were not available to inspectors on the days of inspection. This was a repeat non-compliance also. A number of required inspection documents were submitted following the inspection.

At the time of inspection there was a risk of infection in the centre as a number of residents had acquired an infection following recent hospital admission. Not all cleaning staff spoken with were found to be aware of good infection control practice in relation to cleaning routines. The process to support staff in implementing infection control practices were inadequate. For example, a resident who was reported as being 'barrier nursed' was intermingling with other residents. In addition, the infection control nurse had not visited the centre and the personal protective equipment, gloves, aprons and bags (PPE) were seen stored on the floor outside the resident's bedroom or on the handrails, instead of on a suitable table or trolley. Management staff stated that staff training was delivered for example, on correct hand-washing technique and the use of personal, protective equipment (PPE).

Safeguarding of residents was supported by training and appropriate policies on the prevention, detection and response to abuse. Staff spoken with were clear in their understanding of the procedure for reporting concerns. However, all staff had yet to receive training, even though there had been an increase in training provision since the previous inspection. Following findings on the last inspection receipts were now given for all financial transactions in line with best practice. A restraint register was in place which staff completed whenever bed-rails were used to monitor residents' safety. Inspectors were informed that the centre acted as pension agent for two residents, however, these residents did not have individual, personal bank accounts which is a requirement for undertaking this service. The provider representative stated that this would be addressed.

Significant improvements were required in relation to fire safety:

A second urgent action plan was issued to the provider in relation to the significant risks to the lives of residents and staff in relation to fire safety management. The registered provider representative was requested to arrange for a fire safety risk assessment of the designated centre. The assessment was required to be carried out by a competent professional with suitable experience in fire safety design and management. The assessment was necessary to identify, assess and rate all fire risks throughout the centre. It was to be informed by the resident profile, with particular emphasis paid to the accommodation and fire safety requirements of all residents. Recommendations from the above specialist were required in order to mitigate and reduce all identified risks to an acceptable level. An urgent action plan response, including time lines, was required to be prepared and submitted to the office of the Chief Inspector. The provider was requested to put suitable interim measures in place in the centre until they were deemed by the risk assessment and action plan to be no longer necessary.

Serious and urgent issues in relation to fire safety found on inspection included:

- The provider was not taking adequate precautions against the risk of fire. Three oxygen cylinders were stored in a bedroom with two residents, neither of which required oxygen. Staff were not aware of their location and there was no signage in place to indicate the presence of oxygen, nor were they stored on a suitable stand.
- An immediate action was issued in relation to the removal of the oxygen to an area of safe storage.
- The fire door to the laundry room was held open with a wooden wedge. There was a lot of dust and lint visible on the back of the tumble drier, which presented a high risk of fire.
- Risk assessments were not in place for the safe storage of oxygen, the deficient fire doors or the lack of adequate evacuation procedures.
- The fire drills did not include a simulated full or partial evacuation of the upstairs area where there were a large number of highly dependent residents requiring evacuation on a ‘mattress’. Staff had no practical experience of doing this type of evacuation. It was therefore not possible to ascertain if all residents in the centre could be evacuated to a place of safety in a timely manner in the event of a fire.
- A second immediate action was issued on inspection for the provider to take immediate actions to assure the Chief Inspector that all residents were safe in the centre that night.
- Fire evacuation equipment was not adequate. For example, inspectors could not identify, nor were staff able to demonstrate that appropriate assistive equipment was available for residents who require them to evacuate. Fire evacuation ‘ski-sheets’ were not available for all residents requiring same. There were only 4 such evacuation aids on the premises.
- Fire drill records did not indicate if all staff had attended a fire drill. The names of attending staff had not been recorded for each training session or drill.
- Fire doors required urgent review as they did not appear to be capable of adequately containing smoke and fire due to gaps down the centre where the smoke seals were located. A smoke seal on one door was seen to be repaired

with sticky tape and there was a section of the smoke seal missing on the door of the smokers' room where three residents regularly smoked.
- Some fire doors were held open by mechanisms that could not automatically release in the event of the activation of the fire alarm due to the fact that the mechanism on the end of the door was restricted by the flooring.
- Personal evacuation plans (PEEPS) were located on the inside of each wardrobe door. However, these did not contain identification information.
- There was no evidence that the fire alarm was serviced on a quarterly basis.
- Certification was not available in the centre to indicate that emergency lighting was serviced on a quarterly basis.

Regulation 11: Visits

Visitors were plentiful. Residents were facilitated to out with them and to celebrate special occasions with family and friends.

Judgment: Compliant

Regulation 12: Personal possessions

There was adequate storage and wardrobe space in the centre. Residents had a locked space to store valuables.

Inspectors found that there were two boxes of unlabelled clothes in the laundry room.

Judgment: Substantially compliant

Regulation 17: Premises

Deficiencies in the maintenance of the premises impacted on this finding, particularly in relation to the maintenance of the fire safe doors.

The fact that staff had not had adequate evacuation training from the upstairs department also impacted on the suitability of the premises for the needs of residents' upstairs who required mattress evacuation.

Some areas of woodwork were scuffed from furniture and required to be repainted.

An area of the kitchen flooring had been repaired with yellow tape and this required

repair.

Judgment: Not compliant

Regulation 18: Food and nutrition

Food was plentiful, nicely presented and choice was available. However, one resident who had been assessed as requiring a chopped diet was seen to be served a pork chop on the day of inspection.

Judgment: Substantially compliant

Regulation 26: Risk management

A number of serious risks had not been identified or addressed:

- Deficient fire doors

- Unsafe storage of oxygen

- Ongoing medication risks

- Inadequate evacuation training for staff

Judgment: Not compliant

Regulation 27: Infection control

Processes on barrier nursing and the control of infection were poor.

There were only a small number of hoist slings which were shared between residents, this presented a further infection control risk.

As the cleaning staff were not on the roster it was difficult to ascertain what cleaning hours were available in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

Significant risks identified on inspection, in relation to unsafe fire safety management, as outlined above in the quality and safety dimension in the report resulted in the:

- issuing of an immediate action plan to the provider to address the risks on that day

- issuing an urgent action plan to the provider to address the identified risks and deficiencies within a designated time frame.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

A significant concern remained in relation to the absence of the signatures of some nurses who checked or administered the controlled drugs. Signatures were not available for all such transactions, similar to findings on the previous inspection. Discrepancies were noted on the records with different signatures present for the same times and days on two occasions.

Not all controlled drugs had been returned to pharmacy when no longer required. On one occasion these drugs were used for another resident.

Staff who required supervision were signing for medications, without the signature or supervision of a registered nurse to verify the administration.

All medications had not been transcribed properly.

A complete staff signature and staff initials list was not maintained for staff administering medicines.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were generally well maintained and updated. Allied health care specialists and the GPs documented residents' care.

Care plans were not in place for the residents with infections. In a sample file reviewed care plans had not been put in place for a resident who had a high falls

risk, a leg wound and a modified diet.

Judgment: Substantially compliant

Regulation 6: Health care

Health care provision was good. The GP attended regularly. There was weekly access to the physiotherapist. The speech and language therapist and dietitian were available to residents and for staff training. Chiropody, psychiatry, optical and dental care was accessed. The occupational therapist attended monthly.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Care plans were available for residents experiencing the behaviour and psychological symptoms of dementia (BPSD).

Ten staff had yet to attend this training.

Judgment: Substantially compliant

Regulation 8: Protection

Most staff had received training in the prevention of abuse. A safeguarding plan had been put in place for a resident who had suffered alleged financial abuse.

I staff nurse and eight health care assistants had yet to attend training.

Individual accounts were not maintained for two residents whose pensions were paid into the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents had access to advocacy services. Residents were facilitated to access outdoors and a range of interesting activities. The advocate had visited the centre to meet residents and provide training for staff. Resident meetings were facilitated.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0024922

Date of inspection: 07/11/2018 and 08/11/2018

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to meet regulation 15, based on the findings of recent inspections, we will undertake the following: 1. We will introduce a new system for rostering which will assign responsibilities for rostering to individual managers in the centre, with the final planned roster recorded by the person in charge. 2. The person in charge or clinical nurse manager will check the roster each morning to ensure that all staff rostered to be on duty are present and have signed in. Alterations to the actual roster will be recorded by the nurse in charge. 3. The person in charge will be responsible for keeping records of all planned and actual rosters for the centre. 4. We have also arranged for a review of staffing levels and skill mix to be completed by an external consultant in December 2018. 5. Changes will be made to rostering system based on the findings of the staffing review and include: 6. Development of a staffing plan for the centre based on current and future needs of the centre to comply with regulations. Timeframe: End of December 2018.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

In order to comply with regulation 16, we have arranged for external consultants to mentor the management team in carrying out the following activities:
1. Development of a governance and management framework to outline roles and responsibilities of all grades of staff to include reporting relationships and supervision. Timeframe: Completed.
2. Development of a standard induction programme outlining specific timeframes for completion of induction activities for each new staff member in accordance with their roles and responsibilities.
3. Assigning responsibilities to specific staff members for completion of activities included in the induction programme for staff.
4. Completion of induction records for new staff members to ensure that all aspects of the induction programme have been completed within the agreed timeframes.
5. Assigning responsibility to a named staff member to monitor the induction programme for all new staff members.
6. Completion of an annual training needs analysis for staff in the centre, which will be informed by statutory obligations, feedback from clinical governance activities, changes to residents needs and staff appraisals.
7. Development of an annual training plan for staff in the centre in accordance with their roles, statutory obligations and the training needs analysis.
8. Assigning responsibilities to named managers for completion of the training needs analysis and training plan for staff.
9. Development of training records to record training completed and attendance of staff for each training session provided.
10. The administrative assistant will create an attendance sheet for each training session and will have responsibility for maintenance of records related to training completed and attendance of staff for each training session completed in the centre. Timeframe: To be commenced in December 2018.
11. The clinical governance committee will review training needs at each clinical governance meeting.

Timeframe: 28th February 2019.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
As outlined above, maintenance of training records will be assigned to the administrative assistant.
Regarding fire records, a fire risk assessment is currently being completed and we have engaged an external consultant to mentor the management team and staff on implementation of recommendations arising from same. This will include conducting fire drills and the completion of records for same in accordance with legislation and HIQA 2015 fire guidance. Timeframe: 31st January 2019.

As outlined above a system for rostering will be developed and implemented. Timeframe:

31st December 2018.

The person in charge/CNM or most senior nurse on duty will check each morning that staff rostered for the day shift are on duty. Timeframe: 31st December 2018.

All staff currently have garda vetting and two references in place. These are available for inspection.

The administrative assistance will have responsibility for ensuring that all documents are in place prior to an employee commencing employment. This includes the employment history form.
A standard process for recruitment and selection will be developed and the administrative assistant will be responsible for maintenance of staff files. Timeframe: 31st January 2019.
The person in charge and provider will be responsible for ensuring that all required staff files are in place are in place prior to commencing employment. Timeframe: Immediately.
Audit of staff files will be included in the audit programme and will be the responsibility of the administrative assistant. Timeframe: 28th February 2019.
All resident's records are now stored and filed in locked cupboards.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We have arranged for external consultants to provide mentoring to the management team in carrying out the following activities:
1. Development of a Governance and management Framework for the centre as outlined under regulation 16. Timeframe: Completed.
2. We will develop a clinical governance framework for the centre to include the following:
• Development of a policy for clinical governance in the centre which will outline the clinical governance framework for the centre as well as the roles and responsibilities of all staff for clinical governance according to their roles.
• Establishment of a clinical governance committee for the centre, with specific terms of reference and responsibilities as outlined in the governance and management framework.
• Selection of Key Quality and Safety Indicators for the centre which will be reviewed, trended and analysed by the person in charge, clinical nurse manager and a registered nurse on a monthly basis.
• Review, trending and analysis of complaints.
• Review, trending and analysis of incidents.
• Review of feedback from the resident's forum and / or any satisfaction surveys that

have been completed.
• Development of an annual audit programme for the centre, which is informed by monitoring of the Key Quality Indicators; complaints; incidents; resident feedback; changes to national standards, policy or legislation.
• Review of changes to national standards, policy and legislation which require actions to be taken by the centre to comply with same.
Action 2 Timeframe: 28th February 2019.

3. Development of a planned preventative maintenance plan for the centre under the mentorship and guidance of external consultants. Timeframe: 28th February 2019.
4. Ski sheets have been acquired and are now in place for all residents' beds. All staff have been trained in the use of ski sheets during November.
5. Fire doors in the centre that were not adequate to contain smoke have been adjusted to contain smoke.
6. Smoke seals have been replaced on all corridor fire doors.
7. Automatic release mechanisms are now fitted to the laundry door and those bedroom doors that were unable to close automatically have been adjusted as required.
Timeframe actions 4-7: Completed.
8. A schedule of staff meetings will be developed for all staff to meet with their line manager, provider person in charge. These meetings will be used to provide feedback from both the health and safety and clinical governance committees, discuss any concerns or issues that have been highlighted and to disseminate learning from quality and safety monitoring carried out in the centre. Timeframe: 31st January 2019.

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
We will update the contract of care to include the room number of number of occupants: Timeframe: 31st January 2019.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose will be amended to reflect an updated complaints procedure displayed in the centre. Timeframe: 31st December 2018.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A standard protocol for responding and follow up to incidents will be developed and include a checklist to be completed by the Person in Charge/Clinical Nurse Manager to record follow up actions that have been completed. This checklist will include notifications to the Authority. Timeframe: 31st January 2019.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. The complaints policy and procedures will be amended to outline the appeals process for the centre. Timeframe: 31st December 2018.
2. The clinical nurse manager will be designated the complaints officer for the centre and will receive coaching and mentoring by external consultants to meet the responsibilities of this role.
3. The person in charge will have responsibility for monitoring record keeping in relation to complaints in the centre. (Alternative arrangements will be in place with an external person where the person in charge is the subject of the complaint).
4. Arrangements will be made with an external suitably qualified person to receive appeals about complaints in the centre.
Timeframe: 31st January 2019.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
1. Procedures for medication management in the centre will be reviewed by an external consultant. Timeframe: 31st December 2018.
2. The medication management policy and procedures for all aspects of medication management will be revised and amended in accordance with the findings of the review.

3. Audit of all aspects of medication management will be included in the audit programme for the centre.
4. Weekly audit of administration sheets and controlled drugs records will be carried out for the foreseeable future until compliance with recording by nursing staff is achieved. Timeframe: Immediate.
5. Weekly checks of all areas where medicines are stored will be commenced to ensure that all medicines are in date and that medicines that are no longer in use or have expired are segregated and disposed of in accordance with statutory legislation.
6. Training for nursing staff on medication management, including preventing and responding to medication incidents will be included in the annual training plan for nurses.
7. Training on medication management in accordance with changes to practice and policy will be provided by the external consultant. Timeframe: 1st February 2019.
8. Implementation of fire policies and procedures is outlined in regulation 28.
9. infection control policy and procedures will be revised, amended and implemented as outlined under regulation 27.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
All healthcare staff have been requested to check residents' personal laundry each time the assist with dressing to ensure that personal laundry is labelled.
Timeframe: December 2018.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. As previously outlined a fire risk assessment is currently being completed and arrangements have been made to implement any recommendations from the findings of the review. Timeframe: Commencing December 2018 to be completed by 31st January 2019.
2. Staff have completed ski sheet evacuation training. Timeframe: completed.
3. Reviewing and updating the contents of fire training in accordance with the findings and recommendations of the fire safety risk assessment. Timeframe: Commencing December 2018 to be completed by 31st January 2019.
4. The entrance to a resident's room, which was scuffed will be repainted. Timeframe: December 2018.
The kitchen flooring has been repaired.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
1. Each resident requiring a modified diet will have a mealtime plan which will be made available in all areas where resident's meals are being served.
2. Each nurse will have responsibility for informing the chef on duty regarding any changes to a resident's diet during the nurse's shift.
3. The senior nurse on duty will check with the chef on duty each morning to ensure that information on resident's diet maintained in the kitchen is correct.
4. The person in charge will meet with the head chef on a scheduled basis to discuss residents' food and nutrition needs and any concerns arising from quality and safety monitoring.

Timeframe: 31st December 2018

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
1. We will develop a risk management framework for the centre which will include:
• Processes for identifying occupational and environmental hazards and risks in the environment to residents, staff and visitors. This will be carried out through:
• daily checks of the environment assigned to specific staff members.
• scheduled safety walkabouts carried out by the person in charge and the maintenance operative which will involve completion of health and safety audits
• follow up and investigation of incidents;
• trending and analysis of incidents.
• Risk assessment of hazards and risks identified in accordance with the 5 steps of risk assessment.
• Processes for identifying resident specific risks arising from each resident's disease and health conditions as well as risks arising from specific care planned for the resident. This will be facilitated through the assessment and care planning process.
Timeframe: 31st December 2018.

2. A standard protocol for responding and follow up to incidents. This will include a checklist to be completed by the nurse on duty at the time of the incident as well as a checklist to be completed by the Person in Charge/Clinical Nurse Manager to record follow up actions that have been completed. This checklist will include notifications to the

Authority.
Timeframe: 31st December 2018.

3. A risk assessment of the building and premises will be completed during December 2018 by the external consultants, which will inform the health and safety statement and risk register.
Timeframe: 31st December 2018.
4. A system for reviewing the risk register on a scheduled basis will be developed to ensure it is updated in accordance with current risks in the centre. Timeframe: 31st January 2019.
5. The current health and safety statement and risk management policy will be amended to reflect changes to the risk management framework. Timeframe: 8th February 2019.
6. Mentoring will be provided for the person in charge; clinical nurse manager; maintenance operative and registered provider representative on implementation of the risk management framework. Timeframe: 31st January 2019.
7. Health and safety training for staff in the centre. Timeframe: Commencing December 2018 to be completed by 8th February 2019.
8. A planned preventative maintenance plan for the centre will be developed. under the mentorship and guidance of external consultants. Timeframe: 28th February 2019.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. The infection control policy and procedures for the centre will be revised and amended to ensure that they are compliant with current standards and guidance for infection prevention and control in the centre.
2. The policy will outline roles and responsibilities of all staff for infection prevention and control in accordance with their roles.
3. Data on infections will be gathered, reviewed, trended and analysed by the clinical governance committee on a monthly basis.
4. Training on infection prevention and control will be included in the training plans for the centre.
Timeframe: 28th February 2019.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A fire risk assessment of the centre is currently being completed by an external

consultant.
2. The management team will receive mentoring on implementing the recommendations of this risk assessment and the following actions:
3. Updating the health and safety statement, fire policy and emergency procedures in accordance with the recommendations of the fire risk assessment and health and safety risk assessment carried out by the external consultants.
4. Carrying out scheduled checks of the premises, fire prevention and fire fighting equipment in accordance with statutory obligations and provider guidance (HIQA, 2016).
5. Assigning specific responsibilities to named staff for completion of checks as outlined in the outlined in the governance and management framework.
6. Servicing of fire prevention and fire fighting equipment in accordance with statutory obligations and provider guidance (HIQA, 2016).
7. Assigning responsibility for oversight of the servicing of fire safety equipment and record keeping of same to the maintenance operative
8. Assigning responsibility for internal fire safety checks to the maintenance operative and person in charge which will be outlined in an amended fire policy.
9. Reviewing and updating emergency procedures in accordance with the fire and health and safety assessments carried out by external consultants.
10. Reviewing and updating the contents of fire training in accordance with the findings and recommendations of the fire safety risk assessment.
11. Arranging scheduled fire drills as per the findings and recommendations of the fire safety risk assessment and assigning responsibility for the co-ordination and record keeping of same to named member of staff.
12. Updating the documentation to be completed following a fire drill to ensure it meets the requirements of provider guidance (HIQA, 2016).
13. Establishment of a health and safety committee who will meet on a scheduled basis to monitor health and safety management in the centre. The committee will have specific terms of reference and responsibilities as outlined in the governance and management framework.
Timeframe: 31st January 2019.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. Procedures for medication management in the centre will be reviewed by an external consultant. Timeframe: 31st December 2018.
2. The medication management policy and procedures for all aspects of medication management will be revised and amended in accordance with the findings of the review.
3. Audit of all aspects of medication management will be included in the audit programme for the centre.
4. Weekly audit of administration sheets and controlled drugs records will be carried out for the foreseeable future until compliance with recording by nursing staff is achieved.

5. Weekly checks of all areas where medicines are stored will be commenced to ensure that all medicines are in date and that medicines that are no longer in use or have expired are segregated and disposed of in accordance with statutory legislation.
6. Training for nursing staff on medication management, including preventing and responding to medication incidents will be included in the annual training plan for nurses.
Timeframe: 31st January 2019.

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. Audits of care plan will be included as part of the audit programme for the centre.
2. The person in charge/CNM will check during handovers if care plans have been updated in accordance with changes reported in the standard handover documentation.
3. Training for nurses in assessment and care planning will be scheduled for March 2019.
Timeframe: March 2019.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
All staff will have completed training in managing behaviour that is challenging during January 2019.
Timeframe: 31st January 2019.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Safeguarding training has been sourced for staff from an external provider. All staff on thee current roster in the centre have completed this training.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	31/12/2018
Regulation 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that his or her linen and clothes are laundered regularly	Substantially Compliant	Yellow	31/12/2018

	and returned to that resident.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/12/2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	28/02/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2019
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/01/2019
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and	Substantially Compliant	Yellow	31/12/2018

	served.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/01/2019
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/12/2018
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	31/12/2018
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant		28/02/2018
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission	Not Compliant	Yellow	31/01/2019

	of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	31/12/2018
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	31/12/2018
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Not Compliant	Orange	28/02/2019

	infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	12/11/2018
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant		31/01/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/01/2019
Regulation 28(1)(d)	The registered provider shall 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,	Not Compliant	Orange	30/11/2018

	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.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/11/2018
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant		31/01/2019
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/11/2018
Regulation 29(5)	The person in	Not Compliant	Orange	31/01/2019

	charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	31/12/2018
Regulation 03(2)	The registered provider shall review and revise	Substantially Compliant	Yellow	31/12/2018

	the statement of purpose at intervals of not less than one year.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant		31/01/2019
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/01/2019
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant	Substantially Compliant	Yellow	31/01/2019

	promptly of the outcome of their complaint and details of the appeals process.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/01/2019
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	28/02/2019
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/03/2019
Regulation 5(4)	The person in charge shall formally review, at intervals not	Substantially Compliant	Yellow	31/03/2019

	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.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/01/2019
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/01/2019
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	30/11/2018