Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Larissa Lodge Nursing Home
Name of provider:	Mountain Lodge Nursing Home Limited
Address of centre:	Carnamuggagh, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	25 March 2022
Centre ID:	OSV-0005791
Fieldwork ID:	MON-0036038

About the designated centre

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

The provider plans to provide 24- hour nursing care to 64 residents over the age of 18 years, male and female who require long-term and short-term care (assessment, rehabilitation, convalescence and respite). The building is single storey. Communal facilities and residents' bedroom accommodation consists of a mixture of 48 single and 8 twin bedrooms all with full en-suite facilities. The building is laid out around central communal facilities that include a spacious lounge with multiple areas with views outside and a variety of seating options, an internal dining room with a large skylight, an oratory/prayer room and a visitors room near reception. A variety of outdoor courtyards are accessible from many parts of the building. The philosophy of care is to provide person centred, compassionate care and services with a commitment to excellence through adherence to high standards, disciplined leadership and respect for all.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	37

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 25 March 2022	09:45hrs to 17:45hrs	Nikhil Sureshkumar	Lead
Wednesday 30 March 2022	09:15hrs to 17:45hrs	Nikhil Sureshkumar	Lead
Wednesday 30 March 2022	09:15hrs to 17:45hrs	Catherine Rose Connolly Gargan	Support

What residents told us and what inspectors observed

During this unannounced two-day inspection, the inspectors met and spoke with several residents and visitors. The overall feedback from residents was that the staff were kind and caring in the centre. The inspectors acknowledged that residents and staff living and working in the centre have been through a challenging time during the ongoing COVID-19 pandemic however, significant focus was now required to improve the lived experience of residents in this centre.

On arrival, a staff member guided the inspectors through the infection prevention and control measures necessary before entering the designated centre. This included a signing in process, hand hygiene and an electronic temperature check.

Following an introductory meeting, the person in charge accompanied the inspectors on a walkabout of the centre. The inspectors noted that the communal rooms were bright and spacious however some rooms were not warm enough to be comfortable for residents. The inspectors also found that some residents' bedrooms felt cold and were not kept at at a comfortable temperature for the residents. This was brought to the attention of the person in charge who made immediate arrangements for the temperatures of all areas in the designated centre to be checked and increased for the comfort of the residents.

During the walk around, the inspectors observed that hand sanitisers were available throughout the corridors at appropriate locations. There was adequate signage at key points throughout the centre in relation to infection prevention and control. The signage alerted residents, staff and visitors of the risk of COVID-19 and control measures were in places, such as social distancing and hand hygiene.

Inspectors observed that the food served was nutritious and wholesome The chef on duty was observed interacting with residents to seek their feedback following mealtimes. The inspectors saw that the staff offered menu choices to residents and overall the residents were complimentary about the food provided in the centre. However, improvements were required to ensure that those residents who had a specific dietary care plan were provided with the appropriate meals and snacks.

On the day of the inspection the inspectors noted that staff and resident interactions were largely focused on care activities and there was little conversation or social interactions with residents. This was validated by feedback from residents with one resident telling the inspectors that the staff did not have enough time to chat with them and the activities provided to them were very limited and were not what they wanted to do. Inspectors saw that this feedback was mirrored in a recent residents' survey questionnaire where residents had reported that they were frustrated because the staff did not speak with them enough.

The majority of the residents and families with whom the inspectors spoke were unhappy about the current visiting restrictions in the centre. One resident told the

inspectors that they were sad that their families could not come and visit them in the centre. The inspectors observed that the visiting arrangements that were in place on the day of the inspection were not in line with the national guidance and did not ensure that each resident who wished to meet with their nominated person could do so in private and without restriction.

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

Capacity and capability

The centre's management structure and process, including leadership, required significant improvement to ensure that the centre was brought into compliance with the Care and Welfare Regulations and that residents received safe care and services in line with the centre's statement of purpose. There had been significant changes in the management and leadership team in recent months, including a change in the person in charge. The inspectors found that regulatory compliance in the centre had significantly disimproved since the last inspection and twelve of the regulations inspected were not compliant. As a result, the provider was required to attend a provider meeting following the inspection.

This risk-based unannounced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors reviewed the actions from the compliance plans of the last inspection, the information submitted by the provider and the person in charge, and other information received by the Chief Inspector in relation to the designated centre.

The provider of the designated centre is Mountain Lodge Nursing Home Limited, and the provider is involved in operating two other designated centres in Ireland. The centre benefits from access to and support from centralised departments such as human resources, information technology and finance.

There was a person in charge who worked full time in the centre and who met the requirements of the regulation. They were supported in their role by a newly appointed clinical nurse manager. There was a general manager from the group onsite on the second day of the inspection. The management structure was not clear, and the decision-making responsibilities required realignment to ensure that the person in charge had the authority and the resources to carry out their role.

There were significant changes in the staff in the centre, and a number of newly recruited staff were in post. This created an increased workload for the existing staff in the centre, who were busy training new recruits and well as functioning in their roles. This also led to a lack of continuity of care to the residents.

Although there was some experienced and knowledgeable staff who spoke with the inspectors during the inspection, a number of new staff had not attended mandatory trainings such as safeguarding and fire safety. In addition, staff were not appropriately supervised in their work. As a result, residents did not receive appropriate and timely care in line with their needs.

Inspectors also found that while residents' views were collected, this information was not used to inform the changes and improvements that were required in the designated centre. In addition, complaints were not being managed in line with the requirements of the regulation.

Regulation 14: Persons in charge

A new person in charge commenced in this role in February 2022 and is a registered nurse. They have appropriate experience and a management qualification as required by the regulations.

Judgment: Compliant

Regulation 15: Staffing

The numbers and skill mix of staff were not adequate to ensure residents' needs were met having regard to their dependency levels and the size and layout of the centre. For example:

- On the first day of inspection, two staff were absent on short notice and had not been replaced. As a result, the staffing resources were not adequate, and several residents did not receive their morning care in a timely manner and were still in bed at 12 midday. As a result, inspectors had to source staff to come to assist two residents who required care, one of whom did not have access to a nurse call bell to call staff.
- On both days of the inspection residents' call bells were ringing for long periods and were not responded to promptly.
- At meal times there were not enough staff available to provide support and supervision for those residents who preferred to stay in their rooms to eat their meals.
- Residents who needed additional one to one support did not have this support in place.
- Some residents with approved and funded personal assistance hours were not being provided with the additional care hours to support their care plans.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not facilitated to attend up-to-date mandatory training. For example:

- One staff who had started working in the centre did not have mandatory safeguarding training, and another staff was overdue for safeguarding training.
- Three new staff working in the centre were not facilitated to attend fire safety training.

Furthermore, this inspection identified staff needed further training to ensure they had the necessary skills and competencies to meet residents' needs. For example:

- Staff with responsibility for facilitating residents' social activities have not completed appropriate training to ensure that they have the required knowledge and skills to provide activities for residents with dementia.
- Inspectors noted that a number of staff did not demonstrate safe moving and handling practices. The concern raised by families in relation to moving and handling of residents was validated in this inspection.
- Further training was required for some nursing staff in relation to nursing assessment and care planning as a number of assessments and care plans were either incomplete or not up to to date and did not provide sufficient information for nursing and care staff in relation to each resident's care needs.

Staff were not appropriately supervised according to their role. For example:

- The inspectors noted that a resident did not receive appropriate personal care on the day of inspection. As a result, the resident appeared unkempt and was not dressed in line with their preferences. This had not been identified by nursing staff or managers until the inspector raised the issue with the person in charge.
- On the first day of the inspection the inspectors observed that staff were not adequately supervised in the dining room and as a result some residents did not receive appropriate care and support to eat and enjoy their meals.
- Inspectors also found that care staff were not adequately supervised to ensure that they provided care in line with each resident's specified care plan. For example, records showed that some residents who were at risk of developing pressure ulcers had not been repositioned at regular intervals in line with their care plan. This was not identified by the nursing staff until the inspectors raised the issue with the person in charge.

Judgment: Not compliant

Regulation 21: Records

Not all the records required under Schedule 2 of the regulation were available for the inspectors to review. For example, one staff and one volunteer file were unavailable on the first day of inspection, however the files were made available to the inspectors to review on the second day of inspection.

A review of the Schedule 3 records found that some of the required records were not being maintained in line with the regulations. For example,

- An invoice for one resident's expense was not kept with the residents financial records.
- A resident's petty cash record did not provide a clear and transparent record of how monies had been spent.

Judgment: Not compliant

Regulation 23: Governance and management

There was a management structure in place. However the lines of authority and accountability were not clear especially in relation to decisions such as taking new admissions and staffing requirements to meet residents' needs. In addition, the senior management support for the new person in charge and the clinical nurse manager was not robust and did not ensure that they had the appropriate clinical support in their new roles.

Inspectors found that the staffing resources were not being utilised effectively to ensure that the residents received appropriate care in line with their needs.

There were management systems in place, however, the quality assurance systems did not ensure that the care provided in the centre was safe and appropriate, and this is reflected in the high level of non-compliances found on this inspection. The quality audits and reports reviewed by the inspectors did not identify a number of the non-compliances found on this inspection.

The annual reviews carried out for 2021 had not incorporated the residents' views about the designated centre.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of residents' contracts and found that the contracts did not include an appropriate opt-out clause for any additional service charges imposed on residents. In addition, it was not clear that the residents would be refunded if they did not avail of the additional services made available to them.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

An updated statement of purpose was available in the centre. It contained the information required under Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspectors noted that not all the restrictive practices in the centre were notified to the Chief Inspector as required.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspectors noted that verbal complaints were not documented in the complaints log of the centre as required by the regulation. In addition, the inspectors noted that the centre's complaint procedure did not support effective complaint management and did not meet the regulatory requirement.

The inspectors also noted that the complainants' satisfaction following the investigation of two written complaints was not documented in the complaints log.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The inspectors noted that the centre's policies were not consistently implemented in the centre. For example:

- Mandatory training listed under the centre's own Staff Training Policy was not completed by all staff working in the centre. For example, 17 staff had not attended dementia training and the mandatory communications training listed in the training policy was not scheduled on the centre's training matrix for 2021/22.
- The inspectors found that the record of residents' responsive behaviour (How residents who are living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were not maintained in line with the centre's responsive behaviour policy.
- The designated centre's Policy for Personal Possessions was not comprehensive and did not include the procedures to be carried out to ensure that the residents' clothes were adequately protected. As a result there were not sufficient processes in place to ensure that residents clothes were recorded and managed for example, during laundering.

Judgment: Substantially compliant

Quality and safety

The inspectors found that the quality and safety of care provided to residents living in the designated centre required significant improvement. In addition, the inspectors found that the social care needs of all residents were not being met, and that residents' rights were not upheld in a number of areas. This was particularly a concern in relation to residents being facilitated to enjoy visits with their families and friends which was having a significant impact on the quality of life and well-being of the residents.

At the time of the inspection families were required to book in advance to visit the residents in the centre and the number of families and friends a resident could meet with during the week was also restricted. In addition, those residents who were fully vaccinated and who were identified as a a close contact for COVID-19 were still being required to restrict their movements and to isolate in their bedroom following admission into the centre.

Inspectors also found that new admissions to the designated centre were not being managed appropriately. For example, some residents did not receive a comprehensive assessment of their needs prior to their admission. As a result the person in charge and nursing staff were not clear that the designated centre was a good fit for the residents and would be able to meet their ongoing needs. This was having a significant impact on the other residents especially where the new resident might display responsive behaviours and become anxious or agitated. The inspectors also found that a number of staff lacked the knowledge and skills to provide appropriate support for these residents when they became agitated. As a result, the residents' responsive behaviours escalated, which had an impact on the

other residents.

Overall, residents expressed high levels of satisfaction with the quality of food provided to them and that they had plenty of choices on the daily menus. The inspectors found that the menu was displayed appropriately in the dining room, and overall, the residents were able to make choices on what they wanted to eat. However, this was not consistent for those residents who had specific dietary needs and required an individual meal plan.

Overall, the premises met the needs of residents. However, the inspectors noted that the residents did not have sufficient space to store their belonging in their bedrooms. In addition, there was a lack of storage space available for large items of equipment such as wheelchairs and hoists which were being stored in residents' communal areas. In addition, clinical equipment was stored at a nurses' station on Swilly unit in front of the fire alarm panel and this restricted access to the fire alarm panel in the event of a fire emergency.

The inspectors noted that the centre's general environment was clean. However, the toilets and bathrooms were not clean, and one resident's bedroom was visibly dirty. Staff informed the inspectors that the room had not been cleaned for several days, which was the resident's choice. The inspectors also noted that two vacant rooms had not been deep cleaned when they became vacant.

Regulation 11: Visits

Visiting was overly restricted in the centre, and the arrangements which were in place were not according to the current national guidance. This was impacting the residents' quality of life and well being. For example:

- One resident told inspectors that the ongoing restrictions meant they were confined in the nursing home and had not been able to go out to meet their family members.
- Another resident told the inspectors that they were unhappy about the current arrangements as their family member had not been able to visit them in the designated centre since the start of the COVID-19 pandemic and had only seen them through the window.
- The recent resident surveys carried out in the designated centre clearly indicated that residents were unhappy about the current visiting arrangement. However this information had not been used to review visiting arrangements and to ensure that residents were able to meet with their families safely.

Judgment: Not compliant

Regulation 12: Personal possessions

Inspectors noted that the residents' personal storage space required improvement.

There was inadequate storage space to store personal belongings. For example:

- Two residents did not have bedside cabinets in their rooms, and the residents had to use the window sill to display their personal items of significance, such as photo albums.
- Three residents required more storage or shelf space to store their personal belongings. For example, a resident's radio was kept on the floor, and two residents' flower vase was kept on the floor.
- Most residents' bedrooms had a pleasant alcove seating area. However, in some bedrooms the lack of storage meant that the seating space was cluttered with items such as books, crash mattresses and various items of furniture.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors noted that in some residents' bedrooms and in a number of communal rooms the ambient temperature was cold and did not ensure that residents were comfortable. This was verified by a number of residents who informed the inspectors that the centre felt cold.

The inspectors noted that the centre did not have adequate storage space to store large items of equipment. This created clutter in resident's communal areas.

There were insufficient grab rails installed in residents' bathrooms to support residents' independence. For instance, the inspectors noted that grab rails were only installed on one side of the toilets in several bathrooms. In addition, the inspectors noted that there were no grab rails installed at a wash hand basin in one communal bathroom.

There were not adequate arrangements in place to ensure that essential maintenance was reported and dealt with in a timely manner. The scheduled program of maintenance in the centre and the maintenance records were not available to inspectors at the time of the inspection. In addition key maintenance risks had not been reported and addressed. For example, the inspectors observed that a handrail in one corridor was damaged and posed an injury risk to the residents in the centre.

There were a number of residents accommodated in the designated centre who may display responsive behaviours, however the centre's outdoor garden were not

secure. The two gardens faced a road to the front of the building, and the garden had low gates which were not locked. During the inspection the inspectors observed a resident who had become agitated attempting to climb over the low gate and leave the designated centre.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control in the centre required improvement to meet national standards and other national guidance. For example:

The inspectors were not assured that all areas of the designated centre including equipment used by the residents were cleaned to a high standard. For example:

- Urinals were found on the floor of communal toilets, and inspectors were not assured that they were sufficiently cleaned to prevent residents from getting cross-infections in the centre.
- The cleaning trolley and the cleaning bucket were not clean and were visibly dirty.
- There were several gaps in the centre's cleaning schedule and this had not been identified by supervisory staff.
- Inspectors observed that a resident's bedroom was not clean.
- The inspectors noted that bedrooms were not deep cleaned when they became vacant.

The inspectors noted that the clinical hand wash sinks available near the nurses' station did not meet the recommended specification.

The inspectors noted that appropriate hazardous waste bins were not provided in the sluice room, and this did not support the safe disposal of hazardous waste in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire precautions in the centre had improved since the last inspection, and the provider was found to be proactive in managing the fire safety risks in the centre. The inspectors noted that the action plan following the fire safety risk assessments in the centre was being progressed in line with the time lines.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Inspectors noted that the comprehensive assessments were not completed following the admission of residents. This has resulted in gaps in the provision of person-centred care to the residents and the formulation of appropriate care plans for the residents.

The inspectors noted that the residents' care needs were not accurately reflected in their care plans, and the care plans did not serve as a guidance document for staff to provide the most appropriate care for the residents. For example:

- A number of nursing assessments and care plan reviews did not include key information such as the resident's' mobility needs and dietary needs including weight loss. As a result residents were not referred to appropriate specialist health services in a timely manner.
- Some residents' care plans did not include the prescribed treatment plan advice from specialist health care professionals. As a result, the residents did not receive care in line with their needs. For example, a resident requiring small and frequent diet had not been provided with the recommendations specified by the dietitian.

Judgment: Not compliant

Regulation 6: Health care

The inspectors observed that some residents in the centre did not receive a high standard of evidence-based care in line with their assessed needs. For example:

- Three residents who were at risk of malnutrition did not have an appropriate dietary assessment carried out, and as a result the residents had not been referred to a dietitian.
- Several residents were not referred to a physiotherapist following falls and reduced mobility in line with the centre's own falls management policy..
- A resident had been waiting to be seen by an occupational therapist for the last four months. The occupational therapy assessments were delayed because nursing staff had not submitted an appropriate referral.
- The provider did not make adequate arrangements for three residents to be seen by their General practitioner (GP) following their admission into the centre.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A number of staff did not demonstrate up to date knowledge and skills,appropriate to their role to respond to those residents who displayed responsive behaviours.

The inspectors noted that a resident with responsive behaviour was not appropriately assessed prior to their admission into the centre, and a comprehensive assessment was not carried out following their admission. The resident did not have a mood and behaviour care plan, and the resident's care plan did not support the staff to manage the resident's responsive behaviour in a manner that was not restrictive.

Judgment: Not compliant

Regulation 8: Protection

The inspectors noted that the measures taken to protect residents from abuse in the centre were not robust and did not ensure that all residents were adequately protected. For example:

- The inspectors reviewed the records of the safeguarding investigations that were completed and found that an allegation of abuse was not fully investigated in line with the centre's on policy and procedures.
- The inspectors found that organisational learning following a safeguarding incident were not developed and communicated to relevant staff to prevent the re-occurrence of similar incidents in the future.
- The inspectors found that two new staff did not complete mandatory safeguarding training in the centre.
- A vulnerable adult with a history of safeguarding concerns was discharged into the community without an appropriate community safeguarding discharge plan put in place.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspectors found that significant improvements were required to ensure that residents' rights were upheld and that their feedback was listened to and used to inform how the designated centre was organised and how care and services might be improved. For example:

- The inspectors noted on the first day of inspection that several residents stayed in their rooms and were not provided with meaningful activities. On the second day of inspection, although improved, only a minimal number of residents were brought into the day rooms to participate in activities.
- A number of residents told the inspectors that the activities provided in the centre were not interesting to them.
- The inspectors reviewed the records of residents' surveys, and meetings recently carried out in the centre. Some residents recorded in the surveys and voiced in residents' meetings that the centre's activities required improvement.
- The inspectors noted that the residents who were under 65 years were not facilitated with appropriate social care programs and to access community resources. As a result, the residents did not receive sufficient opportunities to engage in meaningful activities of their choice.
- The inspectors noted that the door to the outdoor gardens was alarmed, and this restricted residents' independent access to the garden. The residents had to wait for staff assistance to deactivate the fire alarm to access the garden area.
- The inspectors noted that the provider had not arranged timely advocacy service for residents. As a result, the inspectors found that residents were not sufficiently supported to exercise their rights.
- The inspectors reviewed a sample of residents' contracts and found that the contracts did not include an appropriate mechanism for residents to choose if they did not wish to avail of any services which might incur additional charges.
- Inspectors were not assured that residents would be refunded if they did not avail of the additional services made available to them.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	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	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Larissa Lodge Nursing Home OSV-0005791

Inspection ID: MON-0036038

Date of inspection: 30/03/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Outline how you are going to come into compliance: Larissa Lodge has in place a staffing tool which supports the PIC & Provider in determining the safe staffing levels based on dependency, our staffing levels exceed the requirements as recommended by the tool. While recruitment presents a challenge for the sector, Larissa Lodge will continue to recruit and retain staff through appraisal and investment in developing competencies and skills. Larissa lodge has since inspection recruited further staff please see below. 1.Continuous recruitment in place. 7 new HCA commenced, and 11 new HCA staff & 8 nurses recruited since 1/4/22. 2. Staff appraisal in place. To have 100% compliance by 30/7/22 3. All new staff have had a completed competency Passport as integral to induction training 100% within 1 month of starting 4. Appraisal compliance and competency assessments reported monthly as part of Governance review 5th of each Month 5. SOP in place for addressing emergency Roster shortfall. 6. Second CNM starting by 7/6/2022 7. 8 nurses undergoing recruitment process by 30/08/2022 8. Regular check list of 5 residents and their environment carried out daily by senior HCA – reported to PIC/CNM 9. On day of inspection the Dining Room was monitored by CNM and will continue to be monitored by Nursing Staff on a daily basis, this is now part of the nursing daily allocation.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development: Eliza care group have a Training Platform in place from 27/5/22 which will address issues relating to outstanding mandatory training. 1. Training compliance reported as part of Governance Review by 5th of each Month by PIC a. Fire 93% (3 staff on induction) 100% compliance by 30/5/22 b. Safeguarding 100% compliance by 13/05/2022 c. MH 98%, 100% compliance by 30/5/22 d. IPC – 100% compliance by 13/05/2022 e. Dementia/positive communication 80%, 100% compliance by 30/6/22 2. New HCA hired to ensure 7 days social care activities being provided and this staff will be enrolled for 'engaging dementia' training 3. People handling competency assessments for all staff and observational audit based on our moving and handing tools will happen on an ongoing basis 4. Nursing assessments and care plans skills workshop with all nurses 100% by 30/06/2022 4. One-to-one care plan audits after each admission. Ongoing 5. Personal care audit will be completed by senior healthcare assistant, which is reviewed by CNM weekly. 6. Nurses' allocation system updated to reflect nurse allocated for dining room supervision 7. All nursing and care staff are updated daily by way of handover report to ensure Skin integrity care plans for all residents reflect their skin condition, need for repositioning where required. Safety cross in place to capture pressure sores and PUSH chart being used to assess the progress of pressure sores, CNM/Nurse will monitor this daily	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. Monthly audit of monies – reported to as part of Governance Review on 5th of each month. 2. Recent audit indicated 100% compliance on 15/4/22 – completed by PIC 3. Schedule 2 Records of starters in previous 3 months have been audited for compliance. 100% compliance by 30/05/22 4. Schedule 2 records will not be filed until complete – Audit tool placed on front of each individual Record as standard practice	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There is a Governance Framework in place – the Governance Review will be audited on site three monthly/as required to ensure the Governance Reporting reflects practice at the point of delivery. The lines of responsibility/authority are clearly outlined as per our Statement Of Purpose.
1. Annual Review was completed for 2022 in line with requirements. However Annual Review going forward will incorporate resident and family views by Jan 2023.
2.Complaints will be thematically analyzed 3 monthly – results made available in the Complaints log all learning will be shared with staff groups and evidenced in staff meeting minutes.
3. Resident's satisfaction and NOK surveys carried out. Actions integrated to QIP
4. Resident's meetings every 3 months. /NOK meeting once a year to discuss/share the outcomes of annual review/care plan of resident. Annual review readily available for both residents and NOKs on request.
5. Regular newsbytes will continue to be issued monthly to NOKs with updates from the previous month.
6. Resident forums and focus groups reported as part of ongoing Governance Review by 5th of every month.
7. Peer clinical support will be provided through group meetings with PICs from other centers and through Monthly Governance Meetings.
8. Monthly Governance Report will be audited on site at a minimum of 3 months – to ensure that action plans and quality audits reflect practice – this will include regulations – 9/23/15/31/34/8/7/4/29/26/28/5.
9. Staff allocations will continue on a daily basis and will continue to take account of care needs/preferences and allocate accordingly.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The Contract of Care is currently being reviewed and will be revised where required by Company Solicitor who will ensure that Contract of Care is in line and in compliance with CCPC Requirement.
The Additional Service Charge for Larissa Lodge is discussed at preadmission and detailed in the current contract of care which have been agreed with all Residents/Next of Kins at point of admission.
The Additional Service Charge covers the following services;
1. Social Programs and Activities
2. Physiotherapy and Occupational Therapy (Group sessions)

3. Dietician
4. Daily Delivery of communal Newspapers
5. Multichannel TVs
6. Specialist equipment, including pressure relieving devices and equipment required to maintain a safe environment.
7. Administration management of Auxiliary Medical and Pharmacy services (example, Speech & Language, Tissue Viability and Dietetic services)
8. Any other services that may be agreed between the parties
9. Toiletries (including soap, shower gel, shampoo, toothpaste, razors etc)

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. Front door and Garden doors included in Notification NF39A/Risk register updated
2. All physical and chemical restraints will continue to be notified in NF39A

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. Schedule 5 Policy on Complaints updated to include informal/verbal complaints.
2. Complainants' satisfaction elicited as part of response to complaint and appendixes to policy.
3. Prior to closure of a complaint, Complainant will be contacted to elicit level of satisfaction, same will be recorded on closure of complaint.
4. In addition, we will also ensure that all learning derived from complaint will be captured and disseminated to required staff to inform practice. With this Complaints will be added to all staff meetings as an agenda.

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. Schedule 5 Policies updated; Residents Possessions & Staff training Policy. SOP in place re laundry management of residents clothing.
2. Managing Responsive behavior training integral to Dementia Training 80% compliance.
3. Reviewed policies available on Training Platform by 01/06/2022. Already available in nurse's desktop and as a hard copy.
4. PRN Psychotropic Medication administration audited monthly – Feb 22 Audit results was 93% - March & April 2022 was 100% compliance.
5. PRN administration of psychotropic medication will continue to be audited monthly for compliance with best practice. The results are reported as part of Monthly Governance Review.

Regulation 11: Visits	Not Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
1. Visiting is in line with National Guidelines – all residents and families informed
2. Access Policy updated to reflect National Guidelines
3. Staff informed through SLING (communication Platform attached to Roster)
4. Visiting in the centre will continue to follow national, IPC and public health guidelines.
5. SOP on social outings updated to reflect national guidelines.
6. Nominated visitor identified for all residents
7. Outcomes of resident satisfaction survey integrated to QIP. Resident feedbacks will be provided in resident forum.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
1. Schedule 5 Policy on Residents Possessions updated to include laundry and replacement of lost or damaged clothing.
2. All residents have a bedside locker available in the room
3. Resident satisfaction with storage facilities will be integral to next Residents forum

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Thermometers available at reception/dining room/day room.
2. Maintenance will check ambient temperatures on a daily basis, recorded in a sign off chart at reception. Mean ambient temperature has been at or above 21 degrees.
3. Audit of internal heating/water temperature and thermostat carried out by Registered Provider and Maintenance 21/4/22 – action plan integrated into maintenance schedule and actioned 3/5/22.
4. Maintenance schedule available
5. Handrail fixed – ongoing monitoring as part of maintenance schedule.
6. Garden gate height to be increased by 30/06/2022.
7. Additional grab rails to be fitted to all communal toilet and individual rooms as indicated through OT assessment
8. Grab rail for hand wash basin in communal bathrooms on both sides to be completed by 20/06/2022.
9. Bookshelf organized for the resident to facilitate proper storage.
9. Designated storage areas for equipment identified and are being monitored daily. This will be checked daily as part of the nurse check list.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. All staff reminded regarding storage of urinals and sluice equipment. No urinals are stored in the communal toilets
2. Clinical waste bins available in Sluice room
3. All resident rooms have received a post C19 deep clean
4. All urinals are for individual use only – resident identifier in place.
5. Housekeeping trolleys included on Housekeeping Cleaning Schedule
6. Deep cleaning schedules reinforced, and check list put in place.
7. Environmental Hygiene Audit carried out twice a week – initial compliance has been 85% - action plan integrated into IPC Quality Improvement Plan. 95% compliance by 30/05/2022.
8. IPC Audit to be 100% compliance 98.6% on 13/05/22. 100% compliance by 30/06/2022
9. IPC course for IPC lead identified with HSE
10. Clinical hand wash basins will be replaced in line with HBN 00- 10 part C recommendations.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1. All prospective residents will continue to have a full preadmission assessment (reflective of VCare Comprehensive Assessment/in line with national screening programs) and a hard copy will be maintained in medical file and updated to the Vcare system which is accessible to all nursing staff.
2. All Care plans have been reviewed by CNM and PDN
3. All care plan evaluations will be fully reviewed by 30/6/22.
4. CNM audits care plans and new admissions (6 admissions/month) 94% compliance in May 22.
5. All nursing staff have had Care plan training on problem identification, writing interventions and care plan evaluation including individual supervision since 1/4/22
6. All referrals for March/April 2022 have been actioned (8 dietician referrals in March 22, and 6 in April 22. 4 SALT referrals in April 22. Ongoing timely referrals will be monitored monthly as part of governance meetings.
7. Care plans to be shared with residents and families where required

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. 79% (35 residents) of residents have had a medical review (in house/telephone) since 1/4/22
2. 83% new admissions have had either an in-house GP visit or a virtual/telephone review. We will continue to work toward inhouse GP visits.
3. 100% of Resident Kardex's have been signed by GP in previous 3 months
4. 53% (24 residents) of residents have had a Physio review by nursing home physiotherapist. 100% compliance with physio reviews by 30/07/2022.
5. Community OT had agreed to assess resident for mobility scooter however resident purchased a motorized wheelchair outside OT assessment. Consequently, OT will not carry out assessment. Referred to OT again and resident placed on waiting list.
6. MDT meeting for resident underage 65 – Holistic social needs assessment completed and referral to OT for Powered wheelchair, weekly day center access once a week.
7. Retinopathy screening for 2 residents scheduled.
8. 5 residents identified as potential beneficiaries of National Bowel screening. - awaiting documentations

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
1. Training on dementia care and positive communication for 20 staff members completed (80%). 100% compliance by 30/06/2022.
2. PRN psychotropic audit – 100% compliance in March 22 and April 22. Nursing Home continues to follow path of minimal use of Psychotropic medication.
3. QUIS Audit indicated predominantly connective +1 and +2 care – repeated monthly
4. Residents assessed as part of preadmission assessment to ensure their psychosocial needs can be met at Larissa Lodge
5. All residents have a Mood and Behavior Care Plan as indicated (23 Mood and Behavior Care plan updated/initiated since 1/4/22

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. Safeguarding training is 100% compliant by 13/05/2022.
2. Compliance with Schedule 5 Safeguarding policy reinforced regarding investigation timelines.
3. Resident's community discharge follow up with Safeguarding team completed 4/5/22 – the resident was discharged in consultation with HSE Safeguarding Officer from the Centre. No further action was required from Larissa Nursing Home. Closure letter awaiting from community social worker.
4. All safeguarding investigations will be carried out in line with Schedule 5 Safeguarding Policy

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Activity care plans to be reviewed to ensure all personal interests have been captured and are reflected in Activity Care plans.
2. The Contract of Care is currently being reviewed and will be revised where required by Company Solicitor who will ensure that Contract of Care is in line and in compliance with CCPC Requirement.
3. We will further engage with residents to encourage further participation and engagement; The Nursing Home provides 54 hours of dedicated activity coordinator time

– outside of ADL care hours
4. Resident specific one-to-one activities will continue to be facilitated for residents who prefer to stay in their rooms.
5. Activity survey to identify resident specific choices and interests along with regular observation audits of activities by CNM/PIC.
6. Gardens will be freely accessible after the gates in garden are raised
7. Residents are provided access to advocacy services as required.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(1)	The registered provider shall make arrangements for a resident to receive visitors.	Substantially Compliant	Yellow	24/04/2022
Regulation 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Not Compliant	Orange	24/04/2022
Regulation 12(c)	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	Substantially Compliant	Yellow	03/05/2022

	particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.			
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	01/04/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/07/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a	Substantially Compliant	Yellow	05/05/2022

	designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/08/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	05/04/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	17/05/2022
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care	Substantially Compliant	Yellow	31/01/2023

	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.			
Regulation 24(2)(a)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.	Substantially Compliant	Yellow	30/06/2022
Regulation 24(2)(d)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the	Not Compliant	Orange	30/06/2022

	resident is not entitled under any other health entitlement.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/08/2022
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	27/04/2022
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	03/05/2022
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective	Substantially Compliant	Yellow	06/05/2022

	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.			
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	03/05/2022
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	06/05/2022
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange	Not Compliant	Orange	01/04/2022

	to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/03/2022
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	18/05/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with	Substantially Compliant	Yellow	30/07/2022

	the resident concerned and where appropriate that resident's family.			
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.	Substantially Compliant	Yellow	01/04/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/06/2022
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to	Substantially Compliant	Yellow	30/05/2022

	that resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	30/07/2022
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	30/06/2022
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	30/06/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	13/05/2022
Regulation 8(2)	The measures referred to in paragraph (1) shall	Substantially Compliant	Yellow	30/05/2022

	include staff training in relation to the detection and prevention of and responses to abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	13/05/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/08/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	13/05/2022
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	31/01/2023
Regulation 9(3)(e)	A registered provider shall, in so far as is	Not Compliant	Orange	13/05/2022

	reasonably practical, ensure that a resident may exercise their civil, political and religious rights.			
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.	Not Compliant	Orange	13/05/2022