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

Issued by the Chief Inspector

Name of designated centre:	Lexington House
Name of provider:	GN Lexington Property Ltd
Address of centre:	Monastery Road, Clondalkin, Dublin 22
Type of inspection:	Unannounced
Date of inspection:	08 May 2024
Centre ID:	OSV-0007910
Fieldwork ID:	MON-0043585

About the designated centre

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

Lexington House is a residential care facility that will provide extended/long term care, respite and convalescence to adults over the age of 18 with varying conditions, abilities and disabilities. Lexington House can accommodate 92 residents, and is located in Clondalkin village. It is within walking distance of the main village and the amenities available. There are 82 single bedrooms and 5 double bedrooms, all of which have en suite facilities. 24-hour nursing care will be provided to all residents, which will be facilitated by a team of registered nurses with support from healthcare assistants. The overall nursing care will be monitored and supervised by the nursing management team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	78

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
Wednesday 8 May 2024	08:42hrs to 17:30hrs	Karen McMahon	Lead

What residents told us and what inspectors observed

From the inspector's observations and from what the residents told them, it was clear that the residents received a high standard of quality and personalised care. The overall feedback from the residents was that the centre was a lovely place to live with plenty of activities and with good quality food available to them.

Shortly after arrival at the designated centre and following an introductory meeting the inspector completed a tour of the designated centre with the person in charge.

The centre was purpose built and registered in 2020. The building was bright, warm and nicely decorated. The centre is laid out across three floors knows as Castle, Newlands and Oakwood. Residents' accommodation was located over the three floors, comprising of 82 single bedrooms and 5 double bedrooms, all of which have en suite facilities. Residents' bedrooms were observed to be bright, spacious and comfortable. Many residents had personalised their rooms with photographs and personal possessions from home. All the rooms had a cosy and homely feel to them and were unique to each of the residents residing in them.

Residents had access to a number of communal day spaces and a dining room on each respective floor. There was additional communal spaces available for residents outside the individual floors, such as a family room and hairdressing salon.

A number of access points on the ground floor opened out to a large enclosed garden. This space was well-maintained and had a suitable ground surface to enable residents who use wheelchairs or mobility aids to access and utilise the space. There was appropriate outdoor furniture and colourful flowers and plants as well as a large water feature to make it a pleasant space for residents. Residents on the first and second floors could freely access the lift to go down to the ground floor to access the garden. Residents who required support to access the garden were seen to be supported.

On both the first and second floor there were large outdoor terraced areas, that were safe and appropriate for residents to use. On the second floor the inspector observed the activity co-ordinator setting up some activities on the terrace for residents, as it was a warm sunny day.

From the inspector's observations, staff appeared to be familiar with the residents' needs and preferences and were respectful in their interactions. Many staff that the inspector spoke with, reported that they had worked in the centre for many years and loved working there. All those spoken with felt supported in their roles and said they were facilitated to take part in continuous training to enhance their role, both mandatory and non-mandatory.

The inspector observed that mealtimes in the centre's dining rooms were relaxed and social occasions for residents, who sat together in small groups at the dining

tables. Residents could attend the individual dining rooms or have their meals in their bedroom if they preferred. A menu was displayed on each dining table. On the day of the inspection, residents were provided with a choice of meals which consisted of lamb or a fish dish, while dessert options included tiramisu or rice pudding.

The inspector observed residents being offered the choice of soup before their main meal. There was a cooked breakfast option, different choices for the tea time meal and sandwiches available in the evening. The inspector observed that the meals provided were of a high quality and well presented. Assistance was provided by staff for residents who required additional support and these interactions were observed to be kind and respectful. Feedback from residents was positive. They reported to enjoy the meals and that portions were plentiful. One resident said that the food was ''beautiful, so tasty''.

There was an activity coordinator working on each floor over the seven days of the week. On the day of the inspection, various activities were planned including reminisce therapy, knitting club, pub quiz and a visit from a therapy dog. The inspector observed residents participating in some of these activities, including the visit from the therapy dog.

The inspector spoke with many residents on the day of inspection. All were positive and complimentary about the staff and had positive feedback about their experiences living in the centre. All residents spoken with said that the staff were very friendly and caring.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being provided.

Capacity and capability

Overall, the findings of this inspection were that Lexington house was a well-managed centre where there was a focus on ongoing quality improvement to enhance the daily lives of residents. The inspector found that residents were receiving good service from a responsive team of staff delivering safe and appropriate person-centred care and support to residents. However, the inspector found that improvements were still required to deal with repeat findings of non compliance with regulation 31; Notification of incidents.

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). This inspection also followed up on the compliance plan from the last inspection in September 2023 and reviewed solicited and unsolicited information

received.

GN Lexington property Ltd. is the registered provider for Lexington House. There were clear roles and responsibilities outlined with oversight provided by the company directors of the registered provider. The person in charge was a registered nurse who was full time in post and had the necessary experience and qualifications as required by the regulations. The person in charge was supported in their role by an administration team and two clinical nurse managers. Nursing staff were supported by a physiotherapist, health care assistants, activity staff, domestic, catering and maintenance staff.

The centre was well-resourced. Staffing levels on the day of this inspection were adequate to meet the needs of the seventy eight residents during the day and night. Staff were supported to attend mandatory training such as fire safety, manual handling and safeguarding vulnerable adults from abuse. A training plan was developed for the coming year to ensure that staff were up-to-date with their training. Supplementary training was also offered to staff in areas such as responsive behaviour (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), restrictive practices and end of life care.

There was a directory of residents made available to the inspector. This had all the required information in relation to residents' admissions and next of kin details. However, the details regarding residents' general practitioner (GP) were incorrect for short term residents in the centre.

The inspector reviewed documentation in relation to a recently submitted three day notification, for an unexpected death. The inspector found that information reported in the NF01 was not reflective of the circumstances around the incident and relevant follow up information had not been submitted. Furthermore, a notification around a safe-guarding concern had been submitted 57 days late, following a response to a request for information made by the office of the chief inspector.

Regulation 15: Staffing

There was an adequate number and skill mix of staff in place with regard to the assessed individual and collective needs of the residents living in Lexington house at the time of the inspection and with due regard to the layout and size of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the training records found that all staff members had access to a variety

of training according to their roles and responsibilities. There was good supervision of staff across all disciplines.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was in electronic format and did not meet the criteria as set out within Schedule 3 of the regulations.For example:

- The GP listed for many short term residents was incorrect.
- One resident had no return date following a temporary transfer to hospital.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider's oversight of incident reporting processes needed strengthening to ensure that:

- all notifiable incidents were recognised by the person responsible for monitoring incidents in the centre.
- all notifiable incidents were notified to the chief inspector within the timeframes required under Regulation 31.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The registered provider had failed to submit a notification in relation to a potential safeguarding incident within the required time frame. The notification was submitted following a request for information from the office of the chief inspector.

Judgment: Not compliant

Quality and safety

The inspector found that the residents were receiving a high standard of care that supported and encouraged them to actively enjoy a good quality of life. Dedicated staff working in the centre were committed to providing quality care to residents. The inspector observed that the staff treated residents with respect and kindness throughout the inspection.

A selection of care plans were reviewed on the day of inspection. A pre-assessment was carried out prior to admission to the designated centre and a comprehensive assessment was carried out within 48 hours of admission to the centre. Care plans were generally individualised and those viewed clearly reflected the health and social needs of the residents.

Residents who required transfer to hospital had all relevant documents, including the national transfer document sent with them. The national transfer document included information on their past medical history, list of current medications and emergency contact numbers. Any changes to care were reflected in the residents care plan, on return to the centre. Transfer documents were saved to the residents file.

Residents reported positively regarding the food on offer in the centre and inspectors found that residents' nutritional and hydration needs were being met. Residents' nutritional status was assessed every month and health care professionals, such as general practitioners, speech and language and dieticans, were consulted when required. Residents individual dietary requirements were clearly communicated to staff. Information on residents individual needs were available in each kitchenette, communication folder's kept at the nurses' stations, the daily handover sheet and more recently,following a learning outcome from an incident in the centre, inside resident's individual wardrobes.

There was an open visiting policy and visitors were observed attending the centre throughout the inspection.Residents could receive their visitors in the privacy of their bedrooms or in a private visiting room as required.

There was a clear safeguarding policy in place that set out the definitions of terms used, responsibilities for different staff roles, types of abuse and the procedure for reporting abuse when it was disclosed by a resident, reported,or observed. Staff had completed safeguarding training.

Regulation 18: Food and nutrition

All residents had access to fresh drinking water. Choice was offered at all mealtimes and adequate quantities of food and drink were provided. Food was freshly prepared and cooked on site. The meals were served hot and in the consistency outlined in residents' individualised nutritional care plan. Residents’ dietary needs were met. There was adequate supervision and assistance provided to those who required it at mealtimes, however independence was promoted. Regular drinks and snacks were provided throughout the day.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

All relevant information was communicated through the form of the national transfer document on resident transfers to hospital or elsewhere. Changes to care, on return to the centre, were reflected in the care plans.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans were individualised and reflective of the health and social care needs, of the resident. They were updated quarterly and sooner, if required.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place. Staff had completed safeguarding training and staff spoken with confirmed to the inspector that they had the appropriate skills and knowledge on how to respond to allegations or incidents of abuse.

The inspector reviewed the documentation in relation to safeguarding incidents that had occurred in the centre. The records showed that these incidents had been appropriately investigated and had relevant learning outcomes put in place.

Judgment: Compliant

Regulation 11: Visits

There was an open visiting policy and arrangements in place to allow visitors to attend the centre to visit residents throughout the day. There were a number of quiet and private spaces available for residents to receive their visitors and guests other than their bedroom should they require it.

Judgment: 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 8: Protection	Compliant
Regulation 11: Visits	Compliant

Compliance Plan for Lexington House OSV-0007910

Inspection ID: MON-0043585

Date of inspection: 08/05/2024

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: Lexington House acknowledges that in error we named the GP for short-term residents as the medical practitioner attending Lexington House, as they would generally be the person consulting with the individual while under our care. Moving forward, we will ensure that our records are reflective of the GP the individual is registered to within the community. We understand one resident did not have a return date following a short stay in hospital due to a clerical oversight. This has now been updated. Moving forward, we have implemented a new procedure as part of the handover when a resident returns from hospital, the CNM2 will oversee this to ensure the procedure is followed and the return date is updated. This will be followed by the PIC each month to ensure compliance with this procedure.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The incident identified was thoroughly investigated over 6 weeks and all learning outcomes were applied. The documentation was shown to the inspector on the day of the inspection. The incident was also appropriately recognized to be safeguarding following the investigation. We acknowledge due to the length of the investigation and the nature of the incident; we did fail to submit one other applicable statutory	

notification within the required timeframe. At the investigation's inception, we did not yet know the details surrounding the incident, they came to light over the investigation. We unfortunately allowed that process to be consuming, meaning the secondary statutory notification was missed. The notification was submitted as soon as we became aware of our error.

A new two-step procedure has been developed and introduced as part of incident investigations within the center. The procedure incorporates a checklist which lists all potential statutory notification and a brief description of each. The investigator must provide the incident summary and the checklist to the registered provider representative who will complete the form, ticking all applicable statutory notifications to be submitted and the date they were sent.

The second step is that the checklist and incident summary is then provided to the PIC who will review the incident and the selected statutory notifications to ensure all appropriate statutory notifications have been selected. The PIC will then check all applicable submissions that have been sent, before signing off on the form as complete. The investigator will require the completed checklist before the investigation can be closed. This ensures that all possible statutory notifications are reviewed against the incident, and the two-step procedure ensures we hold ourselves accountable for submitting the statutory notifications within the required timeframe. This process also ensures the registered provider has adequate oversight of the incident reporting.

These incidents and incident checklists will be reviewed at each governance meeting, held monthly, to ensure we remain compliant.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Lexington House takes all complaints and incidents seriously, we have a comprehensive investigation procedure and all incidents have been thoroughly investigated with learning outcomes applied, as acknowledged by the inspector on the day. We do, however, recognize that we did miss one statutory notification within the required timeframe, amid a difficult and lengthy investigation. We submitted this notification as soon as we became aware of our error.

As per the answer to Regulation 23, a new two-step procedure has been developed and introduced as part of incident investigations within the centre. The procedure incorporates a checklist which lists all potential statutory notifications and a brief description of each. The investigator must provide the incident summary and the checklist to the registered provider representative who will then complete the form, ticking all applicable statutory notifications to be submitted as well as the date they were sent.

The second step is that the checklist and incident summary is then provided to the PIC who will review the incident and the selected statutory notifications to ensure all appropriate statutory notifications have been selected, the PIC will then check all applicable submissions have been sent, before signing off on the form as complete. The investigator will require the completed checklist before the investigation can be closed. This ensures that all possible statutory notifications are reviewed against the incident, and the two-step procedure ensures we hold ourselves accountable for submitting the statutory notifications within the required timeframe. This process also ensures the registered provider has adequate oversight of the incident reporting.

We can assure the authority that moving forward, this comprehensive procedure will ensure we will be compliant within this area.

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 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	09/05/2024
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.	Substantially Compliant	Yellow	13/05/2024
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.	Not Compliant	Orange	13/05/2024