Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Lystoll Lodge Nursing Home
Name of provider:	Lystoll Lodge Nursing Home Limited
Address of centre:	Skehenerin, Listowel, Kerry
Type of inspection:	Unannounced
Date of inspection:	27 May 2025
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0047237

About the designated centre

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

Lystoll Lodge Nursing Home is situated in the countryside, approximately one mile outside the heritage town of Listowel. The centre provides 24-hour nursing care, which is led by the person in charge, who is a qualified nurse. The centre is a two story premises and is registered to accommodate 48 residents. Bedroom accommodation consists of 28 single bedrooms and ten twin bedrooms. There is a variety of communal space, which includes a dining room on the ground floor and three sitting rooms, as well as an internal garden. The centre can accommodate both male and female residents requiring continuing care, respite care, convalescence care, dementia care, psychiatric care and end-of-life care. Admissions to Lystoll Lodge Nursing Home are arranged by appointment, following a pre-admission assessment of needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

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
Tuesday 27 May 2025	15:30hrs to 21:30hrs	Siobhan Bourke	Lead
Wednesday 28 May 2025	09:00hrs to 16:00hrs	Siobhan Bourke	Lead
Tuesday 27 May 2025	18:10hrs to 21:30hrs	Caroline Connelly	Support
Wednesday 28 May 2025	09:00hrs to 16:00hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. The first day of inspection was conducted during the afternoon and evening, followed by a second full day inspection. Over the course of the inspection, the inspectors met with many of the residents, staff and visitors to gain insight into what it was like to live in Lystoll Lodge Nursing Home. Inspectors spoke in more detail with more than 10 residents and six visitors. The inspectors spent time observing the residents' daily life in the centre, in order to understand the lived experience of the residents. A number of residents were living with a cognitive impairment and were unable to fully express their opinions to the inspectors. These residents appeared to be content, appropriately dressed in clothing of their choice and looked well cared for. Residents and visitors generally expressed their satisfaction with the kindness of staff, the quality of the food and attention to personal care. However, a number of residents and relatives told inspectors that at times the centre had been short of care staff in the recent weeks causing delays to care. This is discussed further under Regulation 15; Staffing.

Lystoll Lodge Nursing Home is a designated centre for older people situated in a rural setting, outside the town of Listowel, County Kerry. The centre is a two storey purpose built nursing home, which is registered to accommodate 48 residents. There were 44 residents living in the centre on the days of this inspection. There were bedrooms to accommodate 30 residents on the first floor and 18 on the ground floor, with a lift available for residents' use. The inspectors saw that some bedrooms were personalised with residents' belongings, but some rooms continued to lack soft furnishings, to provide that homely feeling. It was evident to the inspectors that the centre had recently been painted and rooms were observed to be clean. As identified on the previous number of inspections, the layout of some of the privacy curtains in shared rooms, did not ensure that the privacy of both residents could be maintained if the curtains were closed. On the previous inspection in January 2025, the person in charge assured the inspectors that this was being addressed, however this issue remained unchanged. Inspectors also identified on the previous inspections, that a number of bedrooms did not have any televisions available for residents' use, and a number of televisions were not placed where residents could view them with ease. In the action plan response to the previous inspections, the provider committed to this, but it had not been completed to date. Inspectors saw a number of residents, particularly on the first evening of the inspection, in their bedrooms and in their beds early, with no TV or radio for distraction or company. Inspectors saw that there was a programme in place to replace worn and damaged wardrobes and bedside lockers, with a few rooms completed to date. On the second day of inspection, the carpenter was on site and told inspectors that all upgraded furniture would be available in the next number of weeks.

Communal space on the ground floor consists of a main sitting room and dining room, which were just off the main foyer. The inspectors observed that on average

eight to ten residents spent the majority of their day in this sitting room. Four residents had all their meals there. A staff room, on the ground floor was re-purposed as an oratory and had the Stations of the Cross on the walls. This room was available for residents' use, due to the fact that the upstairs chapel was not available to residents, as it was operating as a nurse's station and storage area. As described on the two previous inspections of the centre, the remaining communal space upstairs comprises of one sitting room. The inspectors spent time observing the residents in this area. For a large part of the day, thirteen residents living upstairs were sitting in this room. Many of the residents using this sitting room were observed having their dinner, in armchairs, with a bed table in front of them. There was minimal space between residents. This is discussed further in the report.

The provider had applied to vary the registration of the centre and has submitted floor plans and a statement of purpose to reflect these changes made to the premises including the new oratory and laundry. The provider had also applied to register two large new day rooms to increase the communal space available to residents. However, all the required information had not been submitted to enable these to be registered.

There was easy access to the internal courtyard from a number of unlocked doors in the centre. The courtyard was well maintained, had raised flower beds with brightly coloured flowers in bloom and plenty of outdoor furniture for residents' use.

During the inspection, the inspectors saw that alternatives to bed rails such as crash mats and low beds were in use for many of the residents, as alternatives to bed rails. However, the use of bed rails remained high, with 13 residents having two bed rails in use. Some equipment for residents was not in working order such as a specialist chair was broken, therefore limiting a resident's choice to sit out and a pressure relieving mattress was alarming to indicate a fault. There were no time line provided to inspectors to indicate when these would be addressed. A resident who was a high risk of pressure ulcers was noted not to have pressure relieving equipment in use, this was addressed by the second day of the inspection. These and other findings are outlined further in the report.

Throughout the inspection, the inspectors observed staff engaging in kind and positive interactions with the residents. Staff who spoke with the inspector were knowledgeable about the residents and their care needs. Residents spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. Residents who spoke with inspectors reported feeling safe. However, there had been a recent turnover of staff and residents reported that the centre, was at times, short of staff. A relative told an inspector there were "great staff" but they were "short staffed." On the first day of inspection, there was one less carer rostered on the day shift, due to unexpected leave. This staff member was not replaced. The inspectors noted, on the first evening of the inspection, the lack of the twilight care assistant shift (where care staff were rostered from 4pm to 11pm) particularly on the first floor, where at the time of the inspection, 28 residents were living. There was only one care assistant available to assist residents to bed and answer call bells, as the nurse attended to the medication round, for the early part of the evening. The inspectors also saw that

call bells were not within easy reach, for a number of residents, to enable them to call for assistance on both days of inspection.

During the two days of inspection, the inspectors saw frequent drinks and snacks rounds provided to residents. The inspectors observed the lunch time and evening meal. The inspectors saw that there was a choice of main course for the lunch and residents were also offered a choice at their main evening meal. Residents were complimentary regarding the taste and choice of food available for them in the centre. Since the previous inspections, the improvements have continued in how meals were served to residents with the main course served first, followed by the dessert. The textured modified diets continued to look more appetising. During this inspection, the inspectors saw that more residents from upstairs attended the dining room than on the previous inspections. However, as previously outlined, the remaining residents had their meals on bed tables in front of their chairs, where they spent their day and this did not provide a social dining experience.

The inspectors observed that visiting was facilitated in the centre, throughout the day and there was no restrictions on visitors coming in or taking residents for days out. Overall, relatives spoke highly of the care their relatives received and of the staff, but some identified a lack of activities for their family members particularly in the morning and evening times. A full time activity staff member was employed in the centre to support the activity schedule for residents, Monday to Friday. On the afternoon of the first day, the activity staff was upstairs chatting with residents, doing a quiz and playing music on the TV for about an hour, while there was little activity in the downstairs day room for residents. On the second day, the staff member sat with staff in the downstairs day room and was observed chatting and helping residents read newspapers. An exercise session was held for an hour in the afternoon downstairs. While the residents in the day room upstairs had little meaningful occupation other than watching TV.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre and describes how these arrangements support the quality and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations in this report.

Capacity and capability

This was an unannounced risk inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People (Amendment) Regulations 2022). Previous inspections of the centre undertaken in January 2025, November 2024 and March 2024, found poor levels of compliance with the regulations, particularly in relation to residents' rights, premises issues and governance and management. The inspection of January 2025 identified improvements in safeguarding of residents. Findings of this inspection was that some action had been taken to address the findings of the previous inspection and

while the inspectors acknowledged progress had been made, a number of these actions were ongoing. The inspectors also followed up on unsolicited information submitted since that previous inspection, with regards to care delivery and staffing levels. Evidence was found to support that action was required in the oversight of the service, as evidenced under Regulation 23; Governance and management.

There has been ongoing engagement with the provider, including provider meetings, following the previous inspections, where concern regarding the ongoing decreasing levels of compliance were raised by the office of the Chief Inspector. The provider was also operating the designated centre contrary to condition one of the centre's registration, on which basis the centre is registered by the Chief Inspector. A laundry had been commissioned without an application to the Chief Inspector to vary the centre's conditions of registration as required in the Health Act. Other rooms in the centre had been re-purposed such as the oratory, wash-up room, cold room and staff room. Following these meetings, the provider submitted an application to vary condition 1, to ensure compliance with the regulations would achieved.

The inspection also addressed the non provision of the required information to progress the application to vary condition 1 of the centre's registration. This application was to regularise the use of a laundry room and changes made to the purpose and function of an oratory and staff room. The application also applied for the registration of two new communal areas over two floors which would provide additional sitting rooms for residents. However, further action was required, as although the provider had applied to regularise the use of the laundry, the correct documentation and sign off by a competent person was not available to the inspectors, therefore the provider remained in breach of the centre's conditions of registration. This is outlined further under Registration Regulation 7.

The registered provider of the centre is Lystoll Lodge Nursing Home Limited, which comprises of two company directors. Both directors are engaged in the running of the centre and both of the directors were present for the inspection. The inspectors were informed that the current person in charge was to leave their post at the end of May 2025 and had not worked in the centre since 9 May 2025. The providers confirmed that they were actively recruiting to fill the person in charge position. The Assistant Director Of Nursing (ADON) Position was also vacant. During the inspection, the Clinical Nurse Manager (CNM) was supernumerary and was directing clinical care with the assistance of the staff nurses on duty. There were always two nurses on duty day and night, however the inspectors were not assured that the current governance structure was sufficiently robust and contained the experience required in the management of the centre. The provider had a daily presence in the centre and was assisting with the non clinical management, staff informed the inspectors that the provider was a good support to them. The management team were supported by nursing, health care, catering, activity, housekeeping and administration staff.

From a review of rosters and from speaking with staff and management, it was evident that there were insufficient staffing levels in place to meet the assessed needs of residents. This was due to an increase in the turnover of care staff, in the

weeks prior to the inspection. In addition, management had ceased the evening shift from 4pm to 11pm, which left the centre short staffed in the evening. On the first day of inspection, a staff member was off on unplanned leave and had not been replaced. Rosters reviewed indicated that a number of staff were working extra shifts to cover the rosters, while the provider was in the process of recruiting new staff. The inspectors saw that none of the new staff had commenced employment and were waiting Garda Vetting, which inspectors saw had been applied for and references were secured. During the inspection, the provider agreed to cease admissions to the centre, until key clinical managerial positions were filled and operational, to ensure oversight of the quality and safety of care for residents.

A training matrix was maintained to monitor staff attendance and this was reviewed by inspectors. Improvements in staff training was seen and inspectors saw there was an ongoing schedule of training in place, to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. Further training was planned to ensure all staff had up-to-date training. Although care planning training had been provided to the nursing staff, further training was required as evidenced further in the report.

Inspectors reviewed the accident and incident log and could see that improvements in incident recording, with appropriate management follow up and oversight of incidents. Improvements were also seen in the notification of notifiable incidents to the Chief Inspector. Documentation requested for the inspection was generally provided in a timely manner. The inspectors reviewed staff records and found they were generally compliant with the requirements of schedule 2, with the exception of an updated contract and job description for a recently promoted staff and a record of supervision and disciplinary for another staff member. The inspectors found that other documents were not available including the centre's risk assessments, audit schedules for 2025, minutes of staff and management meetings, as outlined under Regulation 21; Records and Regulation 23; Governance and management.

The centre had a policy for the management of complaints that was written in line with the amended regulations. The inspectors found that there was no complaint recorded since the previous inspection. Complaints evident from a review of residents' records and from a speaking with residents and their relatives were not recorded in line with regulation as detailed under Regulation 34; Complaints procedure.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The provider submitted an application to vary condition 1. However, further supporting documentation was required and was not available at the time of the inspection, to progress the application. In addition, toilets in the new area also required completion.

Judgment: Not compliant

Regulation 15: Staffing

The number and skill mix of staff were not appropriate to meet the assessed needs of the 44 residents living in the centre at the time of inspection. The inspectors were informed that there had been a shortage of care staff and this was evidenced by the rosters seen during the inspection. On the first day of inspection, one member of the care team was absent and not replaced. The provider was actively recruiting to fill recent vacancies, however, inspectors were informed that the twilight health care position(from 4pm to 11pm) had been discontinued, which left the centre short of care staff in the evening.

The inspectors saw that from 8.00pm, there was only one nurse and one care staff to provide care to 28 residents upstairs. The nurse was administering the night time medications, which required full concentration, so should not be disturbed. This left the care assistant alone, to put residents to bed and answer call bells. The inspectors saw that resulted in delays in care provision for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The training matrix was updated with training provided and dates training was next due. Staff and records confirmed that training had been provided to staff in safeguarding and in responsive behaviours over the last number of months. Mandatory training in fire safety, moving and handling and responsive behaviours were in date for staff with evidence of further training planned.

Judgment: Compliant

Regulation 21: Records

The maintenance of some records required action, as the following records the inspectors requested were not available for review on the day of inspection.

- Records of disciplinary action and of supervision of staff, following an incident in the centre; this was a repeat finding from the previous inspection despite assurance from the person in charge following the previous inspection that this would be completed.

- There was no updated contract and job description for a recently promoted staff member.

Judgment: Substantially compliant

Regulation 23: Governance and management

Although some of the findings of the previous inspections had been actioned in particular with regard to safeguarding residents, significant and sustained action was required with the governance and management of the service and the registered provider's requirement to ensure that the service provided was in compliance with the regulations.

The management structure was not clearly defined. Key positions such as the assistant director of nursing position were vacant. There was evidence of attempts to recruit a new person in charge, as the current person in charge was due to leave their post at the end of May. However, the current position holder was not present in the centre since 9 May 2025, therefore oversight of the quality and clinical care for residents was left to a recently promoted clinical nurse manager grade 1.

There was evidence that the provider did not ensure that there were sufficient resources in place to meet the needs of residents, due insufficient staffing levels as outlined under Regulation 15 staffing.

The management systems in place were not sufficiently robust to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by the following:

- There was a lack of oversight of care planning as evidenced under Regulation 5; Individual assessment and care plan.
- With the exception of a wound care audit provided to inspectors, there was no other evidence available of an audit schedule or completed audits available, to provide assurance that the quality and safety of care provided to residents was monitored.
- There was no monitoring of key performance indicators such as residents at risk of malnutrition, falls and pressure ulcers, to identify trends.
- Management systems in place did not ensure residents' rights were upheld as outlined under Regulation 9; Residents' Rights.
- There was a lack of oversight in relation to the submission of applications to vary, by the provider to ensure the premises was ready for inspection and the correct documentation was in place to progress the application, therefore the centre continued to operate outside of condition 1 of its registration.
- There was a lack of oversight of premises issues, including the continued risk associated with the window restrictors in use in the centre, as outlined under Regulation 17

- Management systems in place to ensure complaints were recorded and investigated in line with the regulation 34 required action.
- There was no Annual Review prepared for 2024 nor available in the centre for review.
- There was no evidence or records maintained of staff or management meetings held in the centre during 2025.

The provider was operating the designated centre contrary to condition one of the centre's registration, on which basis the centre is registered by the Chief Inspector. A laundry had been commissioned without an application to the Chief Inspector to vary the centre's conditions of registration as required in the Health Act. Other rooms in the centre had been re-purposed as outlined under Regulation 17; Premises.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors reviewed a sample of incidents and found that notifications reviewed on this inspection were submitted to comply with Schedule 4 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The system in place for the management of complaints in the centre was not sufficiently robust. Complaints management required action to comply with the requirements of regulations, as follows:

- The inspectors found that not all complaints were maintained in the centre including any reviews and outcomes of these complaints in line with the requirements of the regulation. There were no complaints logged since November 2024. However, from speaking with residents and staff, it was evident that other complaints made by residents and their relatives were not recorded.
- There was no records available to indicate that complainants received a written response to indicate whether the complaint was upheld and action taken by the complaints officer as required in the regulations.

Judgment: Not compliant

Quality and safety

Improvements were required to ensure residents living in the centre enjoyed a good quality of life. While residents' needs were being met through good access to health care services, action was required to ensure the quality and safety of care provided to residents was improved, especially with regard to care planning, managing behaviour that is challenging, premises and ensuring residents' rights were promoted at all times.

Inspectors reviewed a sample of residents' nursing and health care records. An assessment of residents' health and social care requirements was completed prior to admission, and this ensured that residents' individual care and support needs could be met. Validated assessment tools were used to assess risks to residents and to inform care planning. Care planning documentation was available for each resident in the centre, however, there were mixed findings in relation to care plans and many were not sufficiently detailed to direct care, and guide staff practice, as outlined under Regulation 5; Individual assessment and care plan.

Residents in the centre had access to medical care from local general practitioners (GPs), who visited the centre as required. There was evidence of regular medical, and medicine reviews in residents' files. There was also access to additional health care services, such as, occupational therapy (OT), physiotherapy, dietetics, speech and language therapist (SLT), chiropodist and palliative care, as required.

Food appeared nutritious and in sufficient quantities, drinks and snack rounds were observed morning and afternoon. Residents who spoke with inspectors gave positive feedback regarding the choice and quality of food provided especially, the home-baked goods in the centre. The dining experienced continued to required action as there was not enough dining space for the residents living in the centre as outlined under Regulation 18 Food and Nutrition.

Inspectors saw, that many staff working in the centre, engaged with residents in a respectful and dignified way during the inspection. The inspectors saw that alternatives to bed rails such as crash mats and low beds were in use. However, bed rails were in use for nearly 30% of residents at the time of inspection as outlined under Regulation 7; Managing behaviour that is challenging.

The inspectors saw that residents' access to a variety of activities during the two days of the inspection had decreased. The activity schedule was led by the activity co-ordinator and was supported by the care staff. Inspectors saw that residents' rights to privacy and dignity was not consistently upheld and evidence of consultation with residents with regards to the organisation of the centre was limited. These and other findings are outlined under Regulation 9; Residents' rights.

There had been some improvements in the premises, with some wardrobes and lockers replaced. The provider assured the inspectors that they would all be replaced as required and the carpenter was in the centre at the time of the

inspection confirmed same. However, other aspects of the premises identified on the previous two inspections had not been actioned such as the installation of new televisions in residents' rooms, further restrictions to the easy opening window restrictors and privacy curtains in shared bedrooms; these are all outlined under Regulation 17 Premises.

Regulation 11: Visits

Visitors were seen throughout the two day's of the inspection to visit their relatives. The communal rooms and private living rooms were utilised. There were no restrictions on visiting,

Judgment: Compliant

Regulation 17: Premises

Not all aspects of the premises conformed to the matters set out in Scheduled 6 of the regulations and in line with the statement of purpose for the centre: Most of the issues listed are repeat findings.

- Available communal space for residents was reduced in the centre and was not in line with condition one of the centre's registration, on which basis the centre is registered by the Chief Inspector. As found on the previous inspections, the Chapel was still being utilised as a nurse's station and storage room. Previously, the registered provider had converted a staff room to an oratory to replace this space. However, this resulted in a reduction of available communal space for residents' by 11 square metres. The lounge area for the centre, which is registered as 25 metres squared of communal space was also not in use for residents during the inspection.
- Further findings that the premises was operating outside the statement of purpose was identified as the laundry was also re-purposed as a wash up room for the kitchen area and a new unregistered laundry was operational onsite.
- There was inadequate dining facilities available for the 44 residents living in the centre at the time of inspection.
- Window restrictors required action as they presented a risk to residents; the restrictors were a hook type and easily opened
- Items of worn bedroom furniture were seen in parts of the centre that required repair or replacement.
- Bedbumpers in a number of bedrooms were worn and cracked. This presented an infection control risk.
- A number of residents' bedrooms did not have any chairs available for residents or relative to sit on.

- The arrangements for storage required action; there was ample storage spaces in the centre, however, they were unorganised and not fitted out with appropriate shelving or storage units. Although shelving had been fitted in some, and management confirmed shelving would be fitted in the remaining store rooms, this was not completed at the time of the inspection. This made these areas difficult to clean.

Judgment: Not compliant

Regulation 18: Food and nutrition

Although there were improvements seen in the presentation and serving of residents meals, further action was required in how residents meals were served.

As identified on the previous number of inspections of the centre, a number of residents were served their meals in the both day rooms. In particular, this was of concern in the upstairs dayroom, where residents were seated very close together from bed tables without sufficient room. This doesn't support a sociable dining experience for the resident.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the good fire safety management systems in place, further improvements were required to ensure adequate precautions against the risk of fire;

- The fire door to the wash room was propped open as the appropriate hold open device was damaged; this is a repeat finding
- The oversight of the personal emergency evacuation plans (PEEPs) required improvement; owing to the transfer to an electronic documentation system, there was both an electronic version and a paper version held in the centre with different information which may cause confusion. Residents who had moved rooms did not have the new room number recorded on their PEEP.
- A bedroom door number was missing which may lead to difficulty in locating the room in the event of a fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

From a review of a sample of care plans it was evident that as found on previous inspections, significant action was required to ensure assessment and care planning was carried out in line with residents assessed needs as evidenced by the following

- A recently admitted resident did not have a care plan developed within 48 hours of admission as required by the regulations. This is required so that staff can provide care in line with residents' assessed needs.
- Residents assessments were not always used to inform care plans; for example a resident with a high malnutrition score did not have this reflected in their care plan.; A resident's weight was not accurately recorded which could lead to errors in their care plan.
- A resident assessed as having a high risk of pressure ulcer development did not have appropriate pressure relieving equipment in use until the second day of inspection.
- Pain assessments were not always completed for residents with wounds such as pressure ulcers.
- From a review of a care plan for a resident with a pressure ulcer, advice recommended from the tissue viability specialist nurse was not evident in the care plan and wound care records.
- Skin integrity records did not consistently reflect residents' current skin conditions.

Judgment: Not compliant

Regulation 6: Health care

Residents living in the centre had good access to GP services, community palliative care services and community mental health services. Where residents developed wounds or were admitted with wounds, access to Tissue viability expertise was available. Action was required in relation to wound assessments as detailed under Regulation 5 Individual assessment and care plan.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Although there had been improvements in relation to the management of responsive behaviours since the previous inspection, the inspectors identified that action was required to reduce the number of bed rails in use as restraint in the centre. The inspectors saw that bed rails were in use for 13 residents which is nearly 30% of

residents at the time of inspection which is not in keeping with a restraint free environment.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action was required to ensure residents' rights were upheld in the centre as evidenced by the following, many of which are repeated findings;

- As found on previous inspections, a number of residents' bedrooms did not have televisions and some televisions when they were in residents' bedrooms were not positioned so that residents could see them easily.
- Residents' rights to privacy in a number of the twin bedrooms was not protected due to the positioning of the screening curtains.
- Many residents who were in bed during the inspection did not have call bells within easy reach, therefore they could not call staff for attention when they required it.
- Residents' meetings had not been held since January 2025 to seek residents views on the running of the service.
- There was lack of communal space in the upstairs sitting room for all the residents living up there. The choice in relation to access to the dining room was restricted, as there was only one sitting for residents at meal times, with space for 17 residents in the dining room. Therefore many residents did not have access to a proper dining experience.
- Activities were limited in the centre to the afternoon in the upstairs day room, on the first day of inspection and the afternoon of the second day of inspection, in the downstairs dayroom. Outside of these times, there was little activation or social stimulation for residents, other than TV, where provided, and newspapers for residents. This resulted in a lack of opportunities for residents to participate in activities in accordance with their interests and capacities.

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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0047237

Date of inspection: 29/05/2025

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**
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: Applications by registered providers for the variation or removal of conditions of registration: We are awaiting documentation from our engineer in order to finalise matters in order to come into compliance.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Day and evening HCA's have been recruited since the inspection and are currently on our roster. We are awaiting Garda vetting for further staff that have been engaged.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Following the inspection an updated contract of employment and job description has been put in the staff member's file	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A new P.I.C has been recruited and has commenced employment.

The audit schedule is been implemented. KPI and quarterly review audit will be completed by September.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The PIC is currently reviewing the complaints procedure.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

We are awaiting documentation from our engineer in order to finalise matters in order to come compliance with space.

The window restrictors are ongoing. Upstairs rooms completed and downstairs is in progress.

The new furniture in all bedrooms is currently been worked on.

All worn bed bumpers are been reviewed and will be replaced.

The shelving will be fitted in storage units.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

We are awaiting final documentation in order to come into compliance for the registration of the new dining rooms. This will support a social dining experience for our residents.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

A new device will be fitted to the wash room door

The bedroom door number will be replaced.

All peeps have been reviewed and updated.

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:

A new check list will be introduced for new admissions, and care plan will be reviewed by CNM within 48 hours of admissions.

All care plans are currently updated and are been reviewed by our new PIC

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:

We have reduced a number of bed rails and the PIC will review to further reduce if possible.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

New TV's have been purchased and other TV's will be repositioned.

Repositioning of screening curtains is in progress.

Call bell audit has been completed and a full review is in progress.

Residents' satisfaction survey is being conducted at present, and a resident's meeting will follow on from this. The result of the survey will also be utilized to develop individual activities by the activity coordinator.

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
Registration Regulation 7 (3)	A registered provider must provide the chief inspector with any additional information the chief inspector reasonably requires in considering the application.	Not Compliant	Orange	30/08/2025
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	31/07/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Orange	30/09/2025

	provide premises which conform to the matters set out in Schedule 6.			
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 served.	Substantially Compliant	Yellow	30/07/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/05/2025
Regulation 23(1)(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	01/07/2025
Regulation 23(1)(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	Not Compliant	Orange	30/09/2025

	details responsibilities for all areas of care provision.			
Regulation 23(1)(d)	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	30/09/2025
Regulation 23(1)(e)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	30/09/2025
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.	Substantially Compliant	Yellow	31/07/2025

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.	Substantially Compliant	Yellow	30/06/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	31/08/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a	Not Compliant	Orange	31/08/2025

	resident's individual care plan.			
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.	Not Compliant	Orange	31/07/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/08/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/09/2025
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is	Not Compliant	Orange	30/07/2025

	reasonably practical, ensure that a resident is facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/09/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/06/2025
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	30/07/2025
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	30/07/2025