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:	Lisheen Nursing Home
Name of provider:	Lisheen Nursing Centre Ltd.
Address of centre:	Stoney Lane, Rathcoole, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	07 June 2023
Centre ID:	OSV-0000059
Fieldwork ID:	MON-0040186

About the designated centre

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

Lisheen is a purpose built privately owned designated centre which has been operating since 1988. Lisheen is a two storey building which has been adapted and extended to provide accommodation for 118 residents over the age of 18 years who need long term care and support. Accommodation is provided in single and twin bedrooms, most of which are en-suite. The centre is named in nine different units, however, it is staffed and managed in seven units, each of which has a dedicated staff team. These units are laid out into homesteads with spacious communal areas served by a small kitchenette. The landscaped gardens are of a dementia friendly design and provide a safe outside space for residents. Lisheen is situated on a landscaped site with views over the surrounding countryside. The centre is a short distance form a local village with shops, community centre and churches. The village is served by public transport routes. There is a large car park to the front of the building and disabled parking is available. Lisheen provides care and support for individuals who require assistance with the activities of daily living. This includes persons with cognitive impairments, dementia and long term mental and intellectual disabilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	116

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 7 June 2023	10:15hrs to 18:00hrs	John Greaney	Lead
Thursday 8 June 2023	09:00hrs to 16:30hrs	John Greaney	Lead
Wednesday 7 June 2023	10:15hrs to 18:00hrs	Bairbre Moynihan	Support
Thursday 8 June 2023	09:00hrs to 16:30hrs	Bairbre Moynihan	Support
Wednesday 7 June 2023	10:15hrs to 18:00hrs	Frank Barrett	Support

What residents told us and what inspectors observed

The overall feedback from residents was that management and staff were kind and caring and that they were happy living in the centre. Inspectors observed that residents appeared to be well cared for, which was supported by comments from residents that staff were responsive to their needs and requests for assistance. Residents were supported to be as independent as possible and inspectors observed residents moving freely around the corridors, communal areas and external courtyards throughout both days of the inspection.

Inspectors arrived to the centre unannounced on the first morning of the inspection. Following an opening meeting with one of the persons in charge, inspectors were accompanied on a tour of the premises. Inspectors availed of the opportunity to introduce themselves to residents in the various communal rooms and occasionally in residents' bedrooms during the tour.

Lisheen Nursing Home is registered to accommodate 118 residents in 92 single bedrooms and 13 twin rooms. All except one of the bedrooms have either individual en suite bathrooms or share a bathroom with the occupants of one other bedroom. There is a communal bathroom within easy reach of the bedroom without en suite facilities. Recent improvements to sanitary facilities included the conversion of some shared bathrooms to individual en suites and the addition of a shower to en suite bathrooms that did not previously have shower facilities. Bedrooms were furnished to a high standard, with adequate space in each room for residents to store personal belongings and possessions. Residents were free to personalise bedrooms to their liking and many had decorated their rooms with photographs and personal mementos.

The centre is a two storey building with bedroom and communal space on both floors. The first floor is accessible by stairs and a lift. The centre is divided into nine units, namely; Appleblossom, Bluebell, Carnation, Daffodil, Elderberry, Fuschia, Gardenia, Heather and Jasmine. For staffing purposes some of the units are combined so that operationally there are seven distinct areas during the day and four areas at night. There are closed circuit television (CCTV) cameras throughout the centre, including in communal rooms. Inspectors were assured by the provider that the CCTV cameras in communal rooms were not operational and the only live cameras were those at entrances and on external grounds. The live feed in the reception area was viewed by an inspector and this corresponded with the provider's assurances.

There are eight main communal areas, primarily comprising a combined sitting/dining room in each area. In addition to the larger communal areas, there is a meeting room and an oratory on the ground floor in Daffodil unit. There is also a private meeting room on the first floor in Heather, but the provider is proposing to convert this to a bedroom. This is the only private meeting room on the first floor. Should residents on the first floor wish to meet with visitors away from their

bedrooms but in private, they would need to go to the meeting room on the ground floor.

Improvements have been made to both of the sitting rooms in Carnation on the ground floor and Gardenia on the first floor. Both have been extended and in addition to providing enlarged communal areas, extending these areas sets part of the communal space away from the main thoroughfare and allows a little more privacy for residents. The communal space in Bluebell is on the main thoroughfare from Fuschia. On entering Bluebell from Fuschia on the days of the inspection, residents were seated on either side of the thoroughfare and this had the potential of interfering with their view of the television.

Residents have access to three internal courtyards. A large chess board was on display in one of these courtyards. The doors to the external courtyard were locked with a keypad access, the number of which was on display on each keypad. The centre had an area on the ground floor called "the village" which contained a faux cottage, post office and a hair dressing salon which was in use. Jasmine unit on the first floor had a door leading out to a balcony and contained two large parasols which were available for residents to protect them from the sun when sitting on the balcony. Management stated that residents did not access the balcony area unsupervised and this was included on the centre's risk register.

The registered provider had employed seven activities co-ordinators. Group activities were available daily for residents and activities were provided on a one to one basis for residents that were unable to participate. Holistic therapies were available for those residents that wished to avail of them and the centre had a large pool table. A small number of residents informed the inspector that they did not participate in activities by choice and preferred to read books. Residents had access to WIFI if required. Daily newspapers were available. Mass was celebrated in the centre once weekly and it was rotated between units. An inspector was informed that a recent remembrance celebration had taken place for residents who had died within the last year. The centre had a dedicated hair salon and a member of staff attended to residents hair.

Residents feedback was sought through resident forum meetings and satisfaction surveys. The satisfaction survey was completed in March and April 2023 with 25 residents responding. The information was not collated and analysed at the time of inspection. On review of resident comments, they were generally positive about the centre with a small number of comments identifying areas for improvement. Resident forum meetings were held three monthly. A resident informed an inspector that she attends the residents' meetings and stated that residents speak up at the meetings and the resident feels that things do get addressed.

The dining experience was observed on both days of inspection in different dining areas. The menu was on display in the centre and residents' informed an inspector that they were provided with a choice. Staff were available to assist residents at mealtimes. Residents were generally complimentary about the food. In April 2023, a dining survey was completed in every unit. In Appleblossom, 11 residents were observed with a follow-up with resident's care plans. This survey identified that

there was a glare in the dining room coming from one of the windows. A new window blind was made and installed accordingly.

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 on the quality and safety of service being delivered.

Capacity and capability

This was an unannounced inspection and was carried out to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The provider had submitted an Application to Vary the conditions of registration to reflect a change in the footprint of the centre, which included increasing the size of two communal areas, a new kitchenette, a new sluice room, a new store room and increasing the size of some bedrooms. The application was also for an increase in bed capacity from 118 beds to 120 beds by converting a meeting/visitors room and a link/sitting area to two single en suite bedrooms. There were also a number of other changes to rooms internally that did not involve a change in the building's footprint. The provider had also submitted an application to renew the registration of the centre as the renewal of registration is due in October 2023.

Lisheen Nursing Home is a family owned and operated nursing home. The registered provider is Lisheen Nursing Centre Limited, a company comprising three directors. The governance structure has recently been changed to further enhance oversight of the day to day operation of the centre. Clinical oversight of the centre is provided by two persons in charge (PICs), both of whom work full time and are also directors of the centre. These are supported by the newly created post of assistant director of nursing (ADON), two clinical nurse managers 3 (CNM 3), two CNM 2s, and four CNM 1s. Non-clinical oversight is provided by a chief financial officer (CFO), an operations manager, a facilities manager and a housekeeping supervisor. Management are supported by a team of nurses, healthcare assistants, activities co-ordinators, administration staff, maintenance staff, catering staff and domestic staff.

There were adequate resources to support residents to receive a high standard of care. On the days of the inspection there were adequate numbers of suitably qualified staff available to support residents' assessed needs. Staff had the required skills, competencies and experience to fulfil their roles. Communal areas were appropriately supervised and staff were observed to be interacting in a positive and respectful way with residents. Staff demonstrated an understanding of their roles and responsibilities.

There were adequate management systems in place to ensure the quality of the service was effectively monitored. A range of clinical and environmental audits had been completed by management. These audits reviewed practices such as infection prevention and control, wound management, medication management, and health

and safety. The person in charge had completed an annual review of the quality and safety of the service for 2022. There was a programme for continuous improvement identified for 2023.

Training records provided to the inspector indicated that all staff had up-to-date training in the areas of safeguarding, manual and people handling, and fire safety. Staff were also supported to attend other training relevant to their role such as infection control, medication management and cardiopulmonary resuscitation. There were appropriate measures in place for the induction and supervision of staff.There were policies and procedures available to guide and support staff in the safe delivery of care. Staff had access to education and training appropriate to their role. This included fire safety, manual handling, safeguarding. While managing behaviour that is challenging is a component of the programme of induction, it was not included as part of the mandatory programme of training.

There was an up-to-date risk register in the centre which identified risks in the centre, and controls required to mitigate those risks. Arrangements for the identification and recording of incidents was in place.

All required policies and procedures as set out in Schedule 5 were available to the inspectors. Policies and procedures had been reviewed and updated as required and at least every three years as stipulated by the regulations.

Records reviewed by the inspector were found to be held securely and were overall found to be accurate, up to date and accessible.

The registered provider and person in charge were aware of their regulatory requirement to notify the Chief Inspector of notifiable incidents that occurred in the centre. A written statement of purpose was in place and available to the inspectors on the day of inspection.

Registration Regulation 4: Application for registration or renewal of registration

The provider had submitted a complete application for the renewal of the registration of the centre. The renewal is due on 04 October 2023.

Judgment: Compliant

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

The provider had submitted a complete application to vary the registration of the centre. The application is for an increase in bed capacity from 118 to 120 beds. The variation also includes the enlargement of two communal rooms and the enlargement of some bedrooms. There are also some changes to the internal

structure of the premises.

Judgment: Compliant

Regulation 14: Persons in charge

There are two persons in charge of this centre. Both persons in charge work full time in the centre and meet the requirements of the regulations in terms of experience and qualifications. Residents spoken with were familiar with the persons in charge and stated that they would have no problem in speaking with them if they had any concerns.

Judgment: Compliant

Regulation 15: Staffing

There were adequate numbers of staff on duty with appropriate skill-mix to meet the needs of the residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

While there was a high level of attendance at training in mandatory areas, responsive behaviour training was incorporated into induction but was not included in the ongoing schedule of training to ensure that staff received updates at regular intervals.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents contained all the information specified in paragraph three of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Inspectors found that the records set out in Schedules 2, 3 and 4 were kept in the centre, and that they were available for inspection on the day of the inspection.

Judgment: Compliant

Regulation 22: Insurance

A contract of insurance was available for review. The certificate included cover for public indemnity against injury to residents and other risks, including loss and damage of residents' property.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that there were strong governance arrangements in the centre. There were sufficient resources in place in the centre on the day of the inspection to ensure effective delivery of appropriate care and support to residents. The provider had management systems in place to ensure the quality of the service was effectively monitored.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a written statement of purpose prepared for the designated centre and made available for review. It was found to contain all pertinent information as set out in Schedule 1 of the regulations and accurately described the facilities and the services provided.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and notification events, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time frames.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were available to staff and all were updated at a minimum of every three years and as required.

Judgment: Compliant

Quality and safety

Overall residents were supported to have good quality of life in Lisheen nursing home which was respectful of their wishes and choices. Residents had access to a high level of medical and nursing care. Furthermore, residents had timely access to health and social care providers. Notwithstanding this regulations requiring action were identified including regulations 17: Premises, 27 Infection control, 28: Fire Precautions, 5: Individual assessment and care planning and 6: Healthcare.

Visitors were observed in the centre during the two days of inspection. It was evident that visitors were welcome in the centre and visitors were complimentary about the care their relative/friend was receiving.

The centre was well maintained throughout. Recent changes to the footprint of the centre had added more space to residents' day rooms, dining rooms and sitting areas. Changes were also made to some bathrooms and bedrooms, which improved the space for the residents. Some issues were highlighted on the Inspection in relation to maintenance of doors and storage. These are detailed further under regulation 17 Premises

Lisheen nursing home was acquired by the current provider in the 1980s and the centre has been upgraded and extended over time. All corridors were nicely decorated with pictures and paintings. Corridors contained assistive handrails throughout. The centre was clean on the day of inspection with few exceptions. The registered provider had identified an infection control link nurse who had completed a one day course in infection control. Inspectors were informed that the infection control link nurse will have protected hours to perform the role. The infrastructure of

the on site laundry supported the functional separation of the clean and dirty phases of the laundering process. This area was well-ventilated, clean and tidy. Since the last inspection the registered provider had maintained a list of all residents with multi-drug resistant organisms (MDROs). A MDRO clinical risk assessment was completed on admission. Staff knowledge on the management of MDROs was generally good. An inspector was shown an information pack that was provided to all staff on information relating to MDROs.

The arrangements to protect residents from the risk of fire were reviewed. Staff training in relation to fire safety was up to date. Fire extinguishers were located throughout the centre and these were regularly serviced. The provider had identified any staff who required refresher training and had scheduled training sessions for those staff members. The provider had developed clear evacuation procedures that should be followed in the event of an emergency. Staff were knowledgeable on these procedures and the number of staff was appropriate to complete the safe evacuation of residents. Fire drills were completed routinely and under differing scenarios. However, improvement was required in relation to the containment of fire. Inspectors noted that although all bedrooms were fitted with fire doors, none were fitted with door closers. This meant that bedroom doors remained in an open position and, as a result, would not be effective at containing fire. The implications of fire doors remaining open in the event of a fire could impact on the containment of fire, and pose a risk to residents if a fire started in close proximity to their room. Staff spoken with did not clearly indicate that closing fire doors was a step in fire evacuation procedures. Furthermore, a number of fire doors were observed to be defective due to damaged or missing smoke seals. This meant that the doors would not function properly in the event of a fire. These, and other fire safety issues are dealt with further under regulation 28 Fire Precautions.

There were adequate arrangements in place for the ordering, receipt, and administration, including drugs that that required additional controls. There were written operational policies and procedures in place on the management of medications in the centre. Medications requiring special control measures were stored appropriately and counted at the end of each shift by two registered nurses. Good medication administration practices were in place and were supported by access to pharmacy services. Some improvements were required in relation to monitoring the fridge temperature and the ambient room temperature in a treatment room.

The standard of care planning was good and described person-centred care interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of pressure ulcers, bed rail usage and falls. Based on a sample of care plans viewed appropriate interventions were in place for residents' assessed needs. Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs. An area for action was identified which is discussed under Regulation 5: Individual assessment and care planning.

Residents had access to general practitioners that attended on site at a minimum of once weekly and as required. Outside of working hours an on-call service was

contacted. A physical therapist attended on site three days a week. The physical therapist did an exercise class with residents and reviewed residents who were unwell. There was evidence from a review of resident records that residents were reviewed frequently by the physical therapist. Occupational therapy was accessed through the health service executive if available or privately. The centre had access to a dietitian, speech and language therapist and tissue viability nurse through a private company.

Management stated that there was a small number of residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Overall there was a very person-centred approach to managing responsive behaviours. Documentation reviewed indicated that the centre was reducing its bedrail usage. Forty three residents had a bedrail in situ in December 2022 and inspectors were informed that this had now reduced to 18 residents. Alternatives measures to restraint were tried and consent was obtained when restraint was in use. The centre had adapted an information booklet for staff on restrictive practices.

There was a policy and procedures in place for the prevention, detection and response to allegations or suspicions of abuse. Staff were familiar with the procedure for reporting suspected abuse.The registered provider had robust systems in place for the management of pensions for those residents that they were a pension agent for.

Resident's rights were protected and promoted in the centre. A resident forum takes place in a different unit every month. Residents from other units are invited to attend. This provided a forum for residents to actively participate in decision-making and provide a feedback in areas regarding social and leisure activities and advocacy. Minimal areas for action were identified in meeting minutes reviewed however, there was a plan to recommence outings for residents.

Regulation 11: Visits

A visiting room on the first floor was being converted to a bedroom. This was the only room on the first floor for a resident to receive a visitor in private away from their bedroom. As a result of the planned re designation of the visitors' room to a bedroom, there would only be one visitors' room in the centre for 118 residents and this is on the ground floor and not convenient to residents on the first floor.

Judgment: Substantially compliant

Regulation 17: Premises

The premises was generally suitable for the needs of the residents living there. Improvements since the last inspection were noted in relation to multi-occupancy bedroom' privacy. Changes to the footprint of the building improved some bedroom and sanitary facilities for residents. Improvements were required to ensure the premises fully met the needs of residents. For example:

Action was required to ensure that the premises is kept in a good state of repair:

- a number of nurses stations located in the circulation space in the corridors were damaged with sections of the panelling peeling off the desk. On the day of the Inspection, the Person in charge advised inspectors that a plan to replace these units was in place. Units in other areas had already been replaced.
- A storage room on the bluebell unit was missing a door.

Action was required in order to ensure that the premises provided suitable storage:

- storage areas were found to be overfilled in some areas. For example, an upstairs store which held items ranging from residents files, to paint, to tools. This area was also partially used as a communications room. Other storage cupboards on corridors were found to be over filled with bedding etc which could impact on the fire detection in the room as bedding was found packed against the ceiling. The provider had commenced addressing these issues on the days of the inspection.

Action was required to ensure there was adequate private areas for residents, particularly in relation to meeting with visitors in private away from their bedrooms.

Judgment: Substantially compliant

Regulation 27: Infection control

Inspectors observed that the centre was generally clean on the day of inspection, however, improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For example;

- The underside of a number of soap dispensers were unclean.
- None of the hand hygiene sinks met the required specifications.
- Inspectors' identified a cleaning product that was being drained into a hand hygiene sink through a tube.
- A number of thermometers were held together with sellotape. This was brought to management's attention on the day.
- While the centre was generally clean the housekeeping room on Fuschia and Jasmine contained dust and debris.
- The policy on carbapenemase-producing enterobacteriaceae (CPE) was out of date and not in line with current guidance.

- Staff were continuing to decant hair and body shampoo from a 5 litre container into wall-mounted containers in each resident's room. Management stated that since the last inspection they had implemented cleaning of the individual dispensers. The registered provider needs to be assured that these are being cleaned in line with manufacturers instructions so that dispensers do not become contaminated with organic material.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had maintained detailed records of servicing of all fire safety equipment. Staff training and fire drills were records and practiced regularly using evacuation aids and varying scenarios. However, some improvement was required:

The registered provider did not take all adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment for example;

- No fire blankets were available at kitchenettes throughout the centre or in the staff canteen area. The provider confirmed that these were put in place prior to the end of the inspection.
- The fire safety risk associated with the use of gas in the laundry was not fully assessed. The procedure for gas shut off was not clear to staff working in the laundry. The management of gas in the laundry at times when the laundry was unoccupied was not clear, for example, it was not clear if a gas leak would be detected at times when the laundry is unoccupied.
- Storage was impacting on fire safety for example, the fire load associated with excessive amounts of combustible material stored in the upstairs storage area was not risk assessed.

The registered provider did not make adequate arrangements for containing fires for example:

- No bedroom fire doors were fitted with self closing devices. This would impact on containment in the event of a fire. Staff spoken with did not clearly indicate that closing fire doors was a step in fire evacuation procedures.
- Some Fire doors had large gaps underneath and around the perimeter.Other cross corridor doors were found to remain open on release of the door closing device. Smoke seals were missing from a number of fire doors in the centre for example; the Carnation sluice room and cleaners store.
- A door was not in place at a storage room in the bluebell unit. This would result in a lack of containment of fire and smoke in the event of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were gaps in the daily fridge temperature records. These records provide assurance that medicines requiring refrigeration are stored at the correct temperature.

The ambient temperature in one of the treatment rooms was recorded at 26 degrees centigrade on a number of occasions. There were some medicines stored in this room with manufacturers instruction that they should not be stored above 25 degrees centigrade.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

An inspector observed that three residents remained in bed during the day. The inspector was informed that the residents got up on alternate days. However, it was not outlined in the care plans reviewed.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical care. A general practitioner attended onsite weekly. Residents were reviewed on request outside of the weekly visit, if required. Outside of normal working hours an out of hours service was used.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of restraint in the centre was used in accordance with national policy. A validated behavioural chart supported residents' with responsive behaviour. Staff were knowledgeable of residents behaviours, and patient in their approach with residents. Training on managing behaviours that challenge is discussed under Regulation 16: Training and staff development.

Judgment: Compliant

Regulation 8: Protection

The registered provider had assurances in place to safeguard residents and protect them from abuse.

- Staff had access to safeguarding training with two staff outstanding on the day of inspection.
- Staff spoken with were knowledgeable about what constitutes abuse, the different types of abuse and how to report any allegation of abuse.
- A sample of records reviewed had the required Garda (police) vetting disclosures in place for staff prior to commencing employment in the centre.
- The registered provider was a pension agent for 13 residents. Systems were in place for the management of residents' finances through a separate client account where residents could access their money. Individual records were kept for each resident that had money in the client account and a monthly statement was issued to residents.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected in this centre. An activities co-ordinator was assigned to each of the seven units. Residents had daily opportunities to participate in group or individual activities. Access to daily newspapers and WIFI was available.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lisheen Nursing Home OSV-0000059

Inspection ID: MON-0040186

Date of inspection: 08/06/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We are happy to see that the inspectors felt that "Staff had the required skills, competencies and experience to fulfil their roles" and that "there was a very person-centred approach to managing responsive behaviours". This clearly indicates that staff are well trained and receive updates on an ongoing basis to inform their high standards of practice. Staff receive training and updates through a variety of means to include: • written literature • clinical handover reminders • HSEland eLearning courses • peer/ one-to-one instruction • reviews of resident safety incidents Furthermore, on the day of inspection inspectors were provided with a training plan document that included further formal training in the area of Dementia care which includes responsive behaviour training.	
Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits:	

The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended, consolidated or replaced from time to time) does not prescribe the number, type or location of facilities for this purpose and simply requires:

11. (2) (b) b) having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required."

All of our main services are on the ground floor, oratory, communal rooms, activities, etc, with additional dining spaces in most other units. These spaces are available to residents to meet with visitors in private when not in use. It also would not be uncommon for residents to go to meet with their visitors at the front entrance and therefore having access to a room on the same floor would prevent them having to go back upstairs. Tea and coffee facilities are also available directly beside the meeting room downstairs which further enhances the experience for all.

Having meeting/ communal spaces on the ground floor would be commonplace in many nursing homes across Ireland and we feel that we have far in excess the number of communal rooms and private spaces than many other nursing homes registered with HIQA notwithstanding exceeding the minimum recommendation of communal space per resident.

The report highlights the many positive improvements we have made to increase our existing communal space and indeed references later in this paragraph that:

"Both have been extended and in addition to providing enlarged communal areas, extending these areas sets part of the communal space away from the main thoroughfare and allows a little more privacy for residents."

The overall effect therefore is a net gain for residents providing more space and privacy through these changes.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As outlined in the inspection report on the day of the inspection, the Person in charge advised inspectors that a plan to replace any nurses stations that had defects was in already in place as was seen on other units where these had already been replaced. The inspectorate must understand that Lisheen is a live building and as defects arise, many variables exist to rectify same such as financial resources & availability of carpenters in this case to which we cannot ignore and must be appreciated.

The door was removed on this "storage room" so to use it as a recess for a full hoist (as previously recommended by the inspectorate) to be stored when not in use. The other items that were in the alcove have since been removed and it will no longer to used a store and only as a recess.

The other concerns raised by the inspector(s) in relation to storage were easily rectifed and completed on the day of inspection. Evidence of same was produced to the inspectors also.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
We will investigate ways in which to improve our infection control practices in line with the regulatory requirements within the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended, consolidated, or replaced from time-to-time) and all appropriate actions will be made in accordance with our Quality Improvement Plan.

We will also continue to be guided by evidence which values the importance of IPC measures as well as appreciating that long term care facilities are first and foremost the residents' home and are very different to the requirements and some practices in the acute setting.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
We appreciate that the inspectors recognise that our fire safety is well managed.

1. Fire blankets complying with Irish Standard I.S. 415: 1998 should be provided in each kitchen where cooking is taking place. Our kitchenettes / tea stations are not formal kitchens nor is our staff canteen. The legislation and our risk assessments indicate that fire blankets are not required in these areas and in the event of a fire occurring in these areas the fire would be best dealt with using a fire extinguisher which are positioned in close proximity to these areas. As per the inspectorate; "the degree of firefighting equipment required will vary from centre to centre depending on its design and layout" and we, along with our Fire consultant feel that they are not statutory in this instance. Nonetheless and as the inspector(s) are aware fire blankets were put in place as requested before the end of the inspection.

2. The staff member on duty on the day of inspection has had refresher training on the procedure for gas shut off. Our gas operated machines are already fitted with gas leak detection systems that automatically shut off in the rare event of a gas leak. Furthermore, and as the inspector(s) are aware a gas detection alarm was also fitted in the laundry before the end of the inspection to further reduce the risk.

3. As the inspector(s) are aware, any concerns raised in relation to inappropriate storage were rectified before the inspection was completed.

4. In accordance with our fire certificate issued by the Building Control Authority in conjunction with SDCC, bedroom door closures are not required in Lisheen Nursing Home. This was reinforced by the Fire Authority during their most recent inspection who found no issues in relation to this. Furthermore, every fire evacuation notice and plan throughout Lisheen states that all doors should be closed in the event of a fire. We also received more accurate information from our Fire Consultant who has assured us that the fire evacuation policy, formal training and drill procedure is specifically deisgned for our building and includes educating staff on closing doors in the event of a fire. Copies of these documents / assurances has been offered to the inspectorate. Whilst our unit based teaching session information sheets did not include a sentence reminding staff to close bedroom doors in the rare event of a fire occuring, this was ammended on the day of inspection and produced to the inspector(s).

5. Any doors highlighted by the inspector(s) on the day had already been brought to the attention of the management team during a recent audit completed by the maintenance team and an action plan was put in place. A formal Fire Risk Assessment with a fire consultant was scheduled for the following month to assess any further need in this area.

6. As outlined above, The door was removed on this "storage room" so to use it as a recess for a full hoist (as previously recommended by the inspectorate) to be stored when not in use. The other items that were in the alcove have since been removed and it will no longer to used a store and only as a recess.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
We are grateful that the inspectorate recognizes that "good medication administration practices [are] in place" in Lisheen. On the day of inspection one fridge out of 8 had gaps in the fridge temperature records and our team have been reminded of the importance of best practice in this area.

During the summer months / warmer days the storage rooms / nurses' stations where

medication may be stored will be fitted with a cooling mechanism to ensure that temperatures do not exceed 25 degrees.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
We appreciate that the inspectorate believes that "based on a sample of care plans viewed appropriate interventions were in place for residents' assessed needs. Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs." and "described person-centred care interventions to meet the assessed needs of residents."

The 3 residents mentioned represent 2.5% of our residents. Two of these residents often decide to stay in bed / get up as and when they please as was referenced in their care review meetings where they and their representative were present. These residents are roommates and as explained to the inspector(s) on the day, chose to have duvet days and watch movies together.

We will endeavour to continue to describe our person-centred interventions as best to meet the inspectorates' expectations.

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(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	01/07/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	01/07/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a	Substantially Compliant	Yellow	01/07/2023

	particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
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.	Substantially Compliant	Yellow	01/07/2023
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	01/02/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/02/2024
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the	Substantially Compliant	Yellow	01/07/2023

	centre.			
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.	Substantially Compliant	Yellow	01/07/2023