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:	14 August 2025
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0047836

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:	43

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
Thursday 14 August 2025	14:00hrs to 21:00hrs	Siobhan Bourke	Lead
Friday 15 August 2025	09:00hrs to 14:50hrs	Siobhan Bourke	Lead
Thursday 14 August 2025	14:00hrs to 21:00hrs	Caroline Connelly	Support
Friday 15 August 2025	09:00hrs to 14:50hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection which was carried out over an afternoon and evening, and inspectors returned to the centre the following day. Two inspectors of social services spent the majority of their time observing care practices, staff interactions with residents as well as speaking with staff, residents and their visitors. The inspectors met with many of the residents during the two days and spoke with 12 residents in more detail. Residents who spoke with the inspectors were full of praise for the kindness of staff working there, with one resident telling inspectors that " staff couldn't be kinder." Residents told inspectors they felt safe living in the centre. Some of the residents living in the centre had a diagnosis of a cognitive impairment and could not converse with inspectors. The inspectors saw that these residents were very comfortable in the company of staff who appeared to be aware of their preferences and dislikes. Staff who spoke with inspectors reported that they found the new person in charge to be very supportive to them, however, some staff identified that the number of staff working on the first floor wasn't sufficient to enable them to meet residents care needs and to give them the time they needed.

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 43 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. There are new extensions to the building which include two large sitting rooms but unfortunately these could not be registered for residents use provider had not secured the correct certification and sign off by a competent person for same.

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. The provider informed the inspectors that while new curtain poles were in place, the privacy curtains were ordered but had yet to arrive to the centre. As outlined on previous inspections of the centre, a number of bedrooms did not have any television. In the action plan response to the previous inspections, the provider committed to this, but it had not been completed to date. The inspectors saw that new televisions had been purchased, but were informed that they couldn't be installed until the new wardrobes were fitted to ensure they were suitably placed for residents. The inspectors saw that the carpenter was on site and was in the process of fitting some new wardrobes for residents. A number of chairs had been placed in some residents bedrooms, while some remained without. In a number of bedrooms, furniture and paintwork were worn and required review or repair; this is outlined further under Regulation 17; Premises.

There was no change to the communal space available for residents with a day room and dining room downstairs and one day room upstairs. The former staff room

that was now in use as an oratory was in use by residents, while a lounge area that opened out to the internal courtyard was being used to store hoists and wheelchairs rather than providing a space for residents to sit and rest. The inspectors saw that the internal courtyard could be freely accessed by residents from the oratory and the lounge. The courtyard was furnished with tables and chairs and well maintained raised beds brightened up the area. Inspectors saw that a large container with a label, stating corrosive solution was inappropriately stored in the courtyard area and an inspector saw that the screw top lid was easy to open. This was identified as a risk to residents living with a cognitive impairment. The provider agreed to action this immediately and removed it from the area. During the two days the inspectors saw residents sitting outside in this area with relatives or on their own to enjoy the August sunshine.

The inspectors saw that there was an increase in the number of crash mats and low beds in use as alternatives to bedrails. Residents who required specialist chairs and pressure relieving equipment were observed using these. The inspectors saw that call bells were within easy reach for residents and residents did not report any delays when they sought assistance.

Residents who spoke with inspectors gave very positive feedback regarding the quality and quantity of food available to them. The inspectors saw that regular drinks and snacks were offered during the two days. The inspectors observed the evening meal on the first day and the lunch time meal on the second day. As found on previous inspections, residents eating in the dining room downstairs were served their meals together from dining tables that were nicely decorated, with condiments available. Four residents were served their meals in the downstairs dining room, three of whom required assistance and were provided with this in a respectful and unhurried manner by staff. Upstairs, 14 residents were served their meals from their armchairs with a bed table in front of them with very little space between residents. This is outlined further in the report.

The inspectors saw that nursing and care staff working in the centre engaged in a respectful and kind manner with residents. Staff who spoke with inspectors were very knowledgeable regarding residents life stories and preferences, such as music preferences, food likes/dislikes and names of family members.Inspectors observed some very person centered interactions between residents and staff. There were many occasions throughout the two days in which the inspectors observed laughter, singing and banter between staff and residents. Residents were supported to go on walks with staff in the outside grounds of the centre.

The inspectors spoke with staff to seek their views on what it was like to work in the centre. Staff told the inspectors that while the staffing levels were adequate on the ground floor, upstairs they required more care staff due to the more complex needs and number of residents. The evening shift had been restored from 6pm to 10 pm for five days a week since the previous inspection, however,the inspectors saw that a member of the night care staff team was working in the laundry at 9pm, when residents on the ground floor may require assistance with going to bed. This is outlined further in the report.

The centre employed an activity co-ordinator who worked in the centre five days a week. There was a schedule of activities in place. During the inspection, feedback from residents regarding the activities was generally positive. However, a relative and resident identified that they would like more variety than was available. There was live music in the centre one day a week. The inspectors saw activity staff engage residents in newspaper reading, a quiz and bingo. A number of residents told the inspectors how they had enjoyed a recent outing to Listowel, where 11 residents were accompanied by staff on a bus to attend a music concert. In July, the new person in charge had undertaken a survey to seek residents views and overall feedback from residents was positive. Residents meetings had not been held in the centre since January 2025, but inspectors saw that the time and date for a meeting on 20 August was displayed throughout the centre. Residents had access to regional and local newspapers and radios.

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 two day unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). The provider submitted an application to renew the registration of the centre and the inspection informed decision making in this regard. The inspectors also followed up on the actions taken by the provider following previous inspections of the centre in May 2025, January 2025 and November 2024, whereby poor levels of regulatory compliance was found with regard to governance and management, staffing, complaints management, residents rights, premises and care planning and protection. While this inspection found improved compliance with protection, care planning and complaints management, significant action was required to comply with the regulations under governance and management, staffing, premises and residents' rights. These findings will be detailed under the relevant regulations of this report.

Significant action was required by the provider to ensure appropriate oversight and management arrangements were in place. An immediate action was issued to the provider on the first day of inspection. Inspectors saw that a large container of corrosive solution was stored in the inner courtyard and it was easy to open. This was a risk, should a resident with a cognitive impairment, inadvertently come in contact with it. The provider removed the container immediately.

The registered provider of the centre is Lystoll Lodge Nursing Home Limited, which comprises two company directors. Both directors are engaged in the running of the

centre, with one director involved in the operational and non-clinical management of the centre and the second director directly involved in the daily maintenance of the centre. As found in previous inspections, the provider was operating the centre outside of condition one of the centre's registration whereby the change and function of rooms had not been regularised and a laundry remained unregistered. The provider had submitted an application to vary condition one of the centre's registration in December 2024. Yet despite regular and ongoing communication with the office of the chief inspector, required additional information such as certification and sign off by a competent person to provide assurance that the construction was in compliance with building regulations was not made available to inspectors. This is outlined further under Registration Regulation 7.

Since the previous inspection in May 2025, a new person in charge had been recruited and commenced in their role on 1 July 2025. This person had the required experience and qualifications to meet the requirements of the regulation pertinent to person in charge. It was evident to inspectors that they were working to ensure oversight of the quality and safety of care provided to residents.

While a number of new care staff had been recruited since the previous inspection, from a review of rosters and speaking with staff, the number and skill mix of staff was not appropriate to meet the assessed needs of the 43 residents living in the centre. The care staff assigned to support residents care needs in the early night had been reinstated from 6pm to 10 pm for five nights rather than seven. Upstairs there were only four care staff assigned to care for 27 residents, which did not meet their assessed needs. The provider assured the inspectors that this gap would be addressed and an extra staff member had been added to the following week's roster. These and other findings are outlined under Regulation 15 Staffing.

It was evident to inspectors that the newly appointed person in charge had commenced a programme of oversight of the quality and safety of care for residents and had commenced collecting key performance clinical indicators such as monitoring falls, pressure ulcers, bedrails, infections and other risks to residents since they commenced their role in July 2025. Inspectors also saw that they had implemented a schedule of audits and had completed audits of call bells,medication management and infection control practices, which was a positive development since the previous inspection.

A number of records were made available to inspectors and from a review of a sample of staff files, inspectors saw that records required under Schedule 2 were maintained for staff. Evidence of performance appraisals and disciplinary action were maintained since the previous inspection. However a number of key governance documents such as the centre's risk register and health and safety statements were not available in the centre. Furthermore, records of management and staff meetings were not available in the centre. For example, records of minutes of staff meetings with nurses and care staff were available for July 2025, whereby these meetings were facilitated by the new person in charge. Records of minutes of previous staff meetings were dated February 2022. Other records of meetings and audits undertaken in the centre were not available in the centre. These and other findings are outlined under Regulation 21 Records and Regulation 23 Governance

and management.

The inspectors saw that the person in charge and the clinical nurse manager ensured staff were appropriately supervised and there was evidence that the person in charge had commenced staff appraisal and supervision plans in place for staff where required. There was an ongoing comprehensive schedule of training in place, to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. From a review of a sample of four staff files, it was evident they were maintained in line with Schedule 2 of the regulations.

From a review of incident records maintained in the centre, required notifications were submitted to the office of the Chief Inspector. The complaints procedure required updating to reflect the change to the complaints officer to the new person in charge. While a written response was seen by inspectors to a significant complainant, it did not meet the requirements of the regulations as outlined under Regulation 34 Complaints procedure.

Registration Regulation 4: Application for registration or renewal of registration

The application for registration renewal was submitted to the Chief Inspector and included all information as set out in Schedule 1 of the registration regulations.

Judgment: Compliant

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 made available to the Chief Inspector in the seven months since the application was submitted. Therefore, the application was refused by the Chief Inspector. These documents were required to provide assurance that the building renovations and works are in compliance with building control regulations.

Judgment: Not compliant

Regulation 14: Persons in charge

A new person in charge had been recently recruited and was full time in position in the centre since 1 July 2025. The inspectors observed that the person in charge was knowledgeable regarding residents' assessed needs and their regulatory remit. They

had the necessary experience and qualifications as required in the regulations.

Judgment: Compliant

Regulation 15: Staffing

Action was required to ensure the number and skill mix was appropriate to meet the assessed needs of the 43 residents living in the centre. Over 46% of residents living in the centre were assessed as maximum or high dependency. While the twilight shift of 6pm to 10pm had been reinstated since the previous inspection, this shift was filled five rather than seven days a week. There were only four care staff rostered to the first floor instead of five to care for the 27 residents living there at the time of the inspection. This caused significant delays in care delivery for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Mandatory training in safeguarding, fire safety, moving and handling and responsive behaviours were in date for staff with evidence of further training planned. The registered provider had a system in place to monitor the uptake of training and this was in place at the time of inspection.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider maintained a directory of residents, which contained information required under the regulation.

Judgment: Compliant

Regulation 21: Records

Key records required for the management and oversight of the service were not available for inspectors to review in the centre; such as the risk register and associated risk assessments, records of management and staff meetings, records of

investigation of incidents and complaints prior to July 2025.

Judgment: Not compliant

Regulation 22: Insurance

The provider had an up to date certificate of insurance available as required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not ensured that resources in the centre were planned and managed to ensure person-centred, effective and safe services, specifically with regard to the allocation and number of care staff as outlined under Regulation 15; Staffing.

Gaps remained in the management structure as the assistant director of nursing position remained vacant.

The management systems in place to monitor and improve the quality of the service required action, to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored, evidenced by the following findings;

- There was evidence of a lack of effective systems in place to monitor staffing, as outlined further under the regulation 15.
- There was insufficient oversight of staff routine practices, inspectors observed that care staff allocated to caring for residents during the night shift, were observed working in the laundry leaving one nurse alone on the ground floor during this time.
- There was insufficient oversight by management to ensure residents rights were upheld, as detailed further under Regulation 9; residents' rights
- there was a lack of oversight of records as identified under records key records required for the management and oversight of the service were not available for inspectors to review in the centre; such as the risk register and associated risk assessments, records of management meetings, records of investigation of incidents and complaints prior to July 2025.
- There was no evidence or records maintained of staff meetings held in the centre from February 2022 until July 2025.
- While it was evident that the newly appointed person in charge had created an audit schedule and had commenced a programme of audit since July 2025, there were no records of audits available to review prior to this time, to

provide assurance regarding the quality and safety of care provided to residents.
- 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, as outlined under Regulation 17; Premises.
- There was no Annual Review prepared for 2024 nor available in the centre for review.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of accident and incident records, notifications required to be submitted to the Chief Inspector were submitted within the relevant time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspectors saw that the complaints procedure was displayed, but required updating to reflect that the new person in charge was now the complaints officer for the centre.

From a review of a written response provided to a complainant, while it detailed the outcome of the investigation, it did not include details of the review process or any learning or recommendations required from review of the complaint as required in the regulations.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures in accordance with Schedule 5 of the regulations were available in the centre.

Judgment: Compliant

Quality and safety

While residents spoke very positively regarding the quality of care staff provided to them, significant action was required to come into compliance with the regulations to ensure the quality and safety of residents. Furthermore some of the findings of the previous inspections had yet to be actioned. In particular, significant action was required in relation to Regulation 17: Premises, and Regulation 9; Residents rights,

The inspectors reviewed a sample of residents' files and found that each resident had a care plan in place that was reviewed and updated every four months. Validated assessment tools were in use to assess clinical risks to residents and inform care planning. Inspectors found that while the standard of care planning had overall improved since the previous inspection, there were mixed findings with regard to documentation of care plans with some person- centred and detailed while others required action as detailed under Regulation 5 Individual assessment and care plan.

There was evidence that residents were reviewed regularly by GPs from local GP practices and referrals were appropriately made to health and social care professionals such as physiotherapists, dietitians, speech and language therapists and occupational therapists.

The inspectors saw that the newly appointed person in charge had reviewed and reassessed the number of restrictive practices in use in the centre and had reduced the number of residents using bed rails from 13 to nine with good evidence of alternatives evident. The inspectors found that staff were up-to-date with training on managing responsive behaviours and interactions observed by inspectors during the inspection were respectful and person centred. Not all restrictive practices had been sufficiently assessed prior to their use as outlined under Regulation 7; Managing Responsive Behaviours.

Food appeared nutritious and in sufficient quantities; drinks and snack rounds were observed morning and afternoon. It was evident to inspectors that there was close monitoring of residents' weights and nutritional assessments. Residents were appropriately referred to dietitian services if required. However, action remained outstanding to improve the dining experience, as outlined under Regulation 18; Food and Nutrition.

Residents who spoke with inspectors reported feeling safe in the centre and staff were provided with training on safeguarding vulnerable adults appropriate to their role.

There was a schedule of daily and deep cleaning of rooms. The inspectors saw that there was an adequate number of housekeeping staff rostered to ensure the centre was clean. The inspectors saw that residents' bedrooms and communal areas were visibly clean and residents who spoke with inspectors reported that their bedrooms

were cleaned on a daily basis. The person in charge was now the lead for infection control and assured inspectors that a member of the nursing staff would be scheduled to attend infection control link nurse training. Some action was required with regard to infection control practices in the centre as outlined under Regulation 27 Infection control.

The fire safety folder was examined and an inspector saw that daily and weekly checks of fire safety systems were recorded and monitored. The quarterly servicing of the fire alarm had been undertaken and regular fire training was scheduled in the centre. Some action was required with regard to fire precautions. Inspectors saw that a fire door was held open upstairs with a bedside locker, this meant the fire door could not close if the fire alarm was activated.This and other findings are outlined under Regulation 28; Fire precautions.

An inspector saw that window restrictors in both floors had been installed since the previous inspection. The inspectors saw that a number of new televisions had been purchased and were stored in the centre awaiting their installation. The curtain poles in a number of the twin rooms had been extended and the inspectors were informed that new privacy curtains for these bedrooms had been ordered and were awaited. However action remained outstanding with regard to premises as outlined under Regulation 17; Premises.

The new person in charge had began a consultation process with residents such as completion of surveys to seek their views on the running of the service. From a review of these surveys, feedback from residents was generally positive. The inspectors saw that call bells were within easy reach for residents and a residents meeting was scheduled for 20 August. However further action was required to ensure residents rights were promoted as detailed under Regulation 9 Residents' rights.

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: Many of the issues listed are repeat findings.

- There was inadequate dining facilities available for the 43 residents living in the centre at the time of inspection.
- Items of worn bedroom furniture were seen in parts of the centre that required repair or replacement.
- 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, but was being used to storage equipment such as hoists and weighing scales.

- Further findings that the premises was operating outside the statement of purpose was identified as the new laundry remained unregistered and other rooms had been re-purposed; such as the previous laundry was functioning as the wash up room for the kitchen area.

Judgment: Not compliant

Regulation 18: Food and nutrition

As identified on the previous number of inspections of the centre, a number of residents were served their meals in the both day rooms. This was of particular concern in the upstairs dayroom, where 14 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 26: Risk management

The risk management policy was updated on the day of inspection to reflect the recent changes to the regulations. An emergency plan was in place to respond to loss of power in the centre. The risk assessment and risk register records were not available to review as detailed under Regulation 23 Governance and management.

Judgment: Compliant

Regulation 27: Infection control

The following required action to ensure compliance with the national standards for infection prevention and control for community services (2018)

- Personal protective equipment (PPE) such as gloves were used inappropriately during the course of the inspection. Inspectors observed two staff members wearing gloves on the corridor, when there was no indication for their use.

- A number of staff were wearing wrist watches and therefore this may impact on the effectiveness of hand washing.
- A bed bumper was observed to be worn and torn and therefore could not be effectively cleaned.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required to ensure compliance in relation to fire precautions as evidenced by the following;

- Simulation of emergency evacuation of the largest compartment had not been undertaken in the centre since April 2025, despite the increased turnover of staff in the centre.
- A fire door leading in to the oratory/ nurses station on the first floor was held open by a locker on the first day of inspection, this was actioned by the nurse on duty.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Action was required to ensure medication records were maintained in line with professional guidelines; as the inspectors saw that where nurses were transcribing, these were not signed in line with the centre's policy and could result in error.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspectors had mixed findings from a review of care plans whereby some residents' care plans were person centred and detailed to direct care; others were not, as evidenced by the following;

- two care plans were not updated following changes to residents' condition, for example when a residents malnutrition score had increased and in one care plan, a resident's wound had healed and the care plans were not updated to reflect these changes.
- incorrect residents' names were noted in the detailed section of the care

plans, whereby the generic name of the core plan was used instead of the resident's name.
- Care plans for residents with responsive behaviours did not contain sufficient information to guide care and inform the staff of triggers to responsive behaviours and of de-escalation methods for staff to use to aid and support the resident.
- In one care plan a resident's preferences for personal care and clothing were not included in their care plan to direct staff.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to GP services, speech and language therapy, dietetic services, occupational therapy services, tissue viability nurse, and physiotherapy services. Residents were reviewed regularly and as required by general practitioners. Community based services such as members of palliative care team and community mental health team attended the centre as required and were onsite on the first day of inspection.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspectors saw that while bed rail usage in the centre had reduced further from 13 to nine residents in the month prior to the inspection, inspectors found that action was required to ensure that all restrictive practices were used with appropriate assessment and multidisciplinary review. For example, a sensor alarm in use to alert staff regarding a resident's movement did not have evidence of appropriate assessment in place. Inspectors observed that staff did not consistently respond to the alarm when it was triggered, which indicated that it may be ineffective.

Judgment: Substantially compliant

Regulation 8: Protection

Staff were provided with safeguarding training and those who spoke with inspectors were knowledgeable regarding the importance of protection and safeguarding of vulnerable adults. Allegations or incidents of abuse were investigated and managed

by the person in charge in line with the centre's policy. Residents who spoke with inspectors reported that they felt safe living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

While some improvements to residents rights was evident, the following repeated findings required action to ensure residents' rights are upheld in the centre;

- 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 due to limited space. 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.
- While posters displayed in the centre demonstrated that there was a resident's meeting scheduled for August 20th; a residents' meeting had not been held since January 2025.These are required so that residents are consulted on the running of the service.
- The positioning of the privacy curtains in the twin rooms remained a concern, as they not ensure residents' privacy was protected.
- 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.

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 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	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	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	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0047836

Date of inspection: 15/08/2025

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: A new Application with the supporting documentation will be submitted by the registered providers for the variation or removal of conditions of registration no later than February 2026.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Recruitment is ongoing. A new ADON will commence from 1st October 2025. 2 full time care staff has been recruited to fill the vacancy in September 2025. A full time senior care staff is also returning to work. • Weekly staff roster reflects adequate skill mix and staffing levels to meet the assessed needs of the residents in the nursing home. Twilight shift of 6-10pm is available seven days a week.	
Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records: Provider will ensure that going forward key records for the management and oversight of the service will be stored securely.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A new ADON is recruited and will commence from October 1st. Where possible two CNM's were working Mon-Friday to ensure adequate supervision and oversight of staff on both floors. • Actions were taken by PIC to ensure carers are not working in the laundry. CNM is rostered for night duty to ensure management oversight. Laundry management has been addressed effectively by utilising the existing laundry staff and additional resources has been made available by the provider. • Provider will ensure the maintenance and retention of records as per regulation going forward. To facilitate adequate oversight of records a robust IT system will be installed. • Going forward meeting minutes records will be maintained and stored securely. • A new Application with relevant documents will be submitted by the registered providers for the variation or removal of conditions of registration no later than February 2026. • Provider will ensure the premises will be maintained to comply with the regulations no later than February 2026. ***The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.***	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Complaints procedure displayed reflects the new PIC as the complaints officer. Response to the complainant will be reviewed to comply with the complaints policy and procedure	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A new Application will be submitted by the registered provider for the variation or removal of conditions of registration no later than February 2026. This includes registration of a new chapel, laundry facility , wash up area, additional dining area and communal spaces on both floors.
• Lounge area is available and utilized daily by the residents.
• A separate space has been allotted for storage of hoists and weighing scales.
• Provider will review the existing SOP.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
All residents are encouraged to have meals in the dining room. Currently additional residents are coming to dining room for meals. Provider will submit a new registration application for the additional new dining space available in the facility.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Observational audits are conducted regularly to ensure PPE are used appropriately by all staff.
• The worn bed bumper was removed.
• Infection prevention and control policy is communicated to all staff and daily hand hygiene demonstration.
• Weekly and monthly IPC audits are ongoing.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire warden training was completed by designated fire wardens on Sep 16th, 2025.

• For day and night staff simulation of fire drill and evacuation is planned for October 16th and 29th , 2025.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Transcribing is done as per the medication management policy.

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:
• All care plans were reviewed. Audits were conducted to ensure compliance.
• Behaviour support plans were made for residents who has responsive behaviours.
• Care planning workshop was held for nurses on 03.09.2025 to ensure person centred care plan.

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:
• Care plan and assessment of the resident using sensor alarm was reviewed.
• Staff are allocated daily to respond to the sensor alarm.

• Audits are conducted to ensure consistent response to the alarm.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A number of residents who utilized the first floor communal space are now using the available lounge area and dining room.
• A new Application will be submitted by the registered providers for the variation or removal of conditions of registration no later than February 2026. This includes registration of additional dining area and communal space on both floors.
• Resident meeting was held on August 20th, 2025 as scheduled and minutes were made available to residents.
• Televisions are installed in resident's bed rooms and positioned correctly so that they can be viewed easily.
• New privacy curtains will be in position by 30th October 2025.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

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	28/02/2026
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	30/10/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Not Compliant	Orange	28/02/2026

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	28/02/2026
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	28/02/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/11/2025
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years	Not Compliant	Orange	01/07/2025

	after the resident has ceased to reside in the designated centre concerned.			
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	30/10/2025
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 details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	01/10/2025
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	30/04/2026
Regulation 23(1)(e)	The registered provider shall ensure that there is an annual review of the quality and safety of care	Not Compliant	Orange	30/04/2026

	delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.			
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is implemented in the designated centre, as required.	Substantially Compliant	Yellow	15/09/2025
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	30/11/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals,	Substantially Compliant	Yellow	30/10/2025

	that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	30/08/2025
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.	Substantially Compliant	Yellow	30/10/2025
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	30/09/2025

	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.			
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	20/09/2025
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident is facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media.	Not Compliant	Orange	15/09/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident	Not Compliant	Orange	20/09/2025

	may undertake personal activities in private.			
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.	Substantially Compliant	Yellow	20/08/2025