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

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|---|---|
| Name of designated centre: | Larissa Lodge Nursing Home |
| Name of provider: | Mountain Lodge Nursing Home Limited |
| Address of centre: | Carnamuggagh, Letterkenny, Donegal |
| Type of inspection: | Unannounced |
| Date of inspection: | 26 November 2024 |
| Centre ID: | OSV-0005791 |
| Fieldwork ID: | MON-0041180 |

## About the designated centre

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

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

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 51 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Tuesday 26 November 2024 | 10:00hrs to 18:00hrs | Nikhil Sureshkumar | Lead |
| Wednesday 27 November 2024 | 10:00hrs to 13:00hrs | Nikhil Sureshkumar | Lead |
| Tuesday 26 November 2024 | 10:00hrs to 18:00hrs | Gordon Ellis | Support |

## What residents told us and what inspectors observed

The feedback from residents was generally positive, and it was clear that residents were enjoying a good quality of life in the centre. Some residents' comments were that "the food is nice here, staff are really supportive", "the care is good", "I like my bedroom. It is nice, and I have plenty of space to keep my indoor plants in my room."

Larissa Lodge Nursing Home is a single-storey building located close to Letterkenny Town with access to local amenities. The residents are accommodated in two units in this centre, namely the Swilly and Errigal wings. The centre has 48 single-occupancy rooms and eight double-occupancy rooms. The centre is registered for 64 beds, and there were 51 residents accommodated in this centre on the day of inspection. The premises were found to be clean and had a welcoming ambience.

This unannounced inspection was carried out over two days, and the inspectors met with the person in charge upon arrival at this centre. The centre had a visitors' rooms adjacent to the reception area, which had sufficient seating for residents to receive their visitors. The centre has spacious day rooms and a large dining room with a sufficient number of comfortable chairs for residents to sit and relax. The inspectors observed that the residents had unrestricted access to the outdoor garden areas.

Residents who were in communal areas were observed, in general, to be supervised by staff, and they seemed content and relaxed in the company of staff. Residents were seen to have positive interactions with staff on both days of the inspection.

The inspectors observed that there was a schedule of activities programme, which included activities such as painting, Mass on television, structured walks, rosary, chair exercise and yoga, tea and chats, movie time, sing-along, bingo, colouring sessions and one-on-one sessions for those who did not participate in group activities sessions. The inspectors observed that one activity coordinator was available to provide social care programmes for 51 residents on the day of the inspection. The inspectors spoke with some residents and sought their experience regarding social care programmes. Some residents who engaged with the inspectors indicated their appreciation for the group social care programmes. Two residents expressed a preference for not participating in such activities, opting instead to remain in their individual rooms, and their choice was respected.

The inspectors reviewed the layout of a sample of 11 bedrooms in this centre, three of which were not occupied on the day of inspection. The inspectors observed that three of the single occupancy rooms of residents were personalised with their belongings. Residents in these three rooms were provided with additional shelving space to store their personal belongings. The residents who spoke with the inspectors said that they felt their rooms were homely. However, this was not the case for all residents, and the inspectors saw that two residents in single occupancy

rooms and five residents in double-occupancy rooms did not have adequate storage facilities to store their personal belongings. As a result, seven residents had to keep their personal items of significance, such as photo albums, behind the bedheads. This was brought to the attention of the management team, and they informed the inspectors they had already identified it as an area for improvement.

There was no restriction on visiting in this centre, and the residents who engaged with the inspectors expressed their satisfaction with the current visiting arrangements in place.

There was a variety of food on offer for the residents. Staff were aware of the preferences and choices of residents regarding their meals. The dining area allowed for social interaction between residents. Residents were supported when required by staff, and staff interacted respectfully with them during meal times. Snacks and drinks were available to residents at various times.

The inspectors observed inappropriate storage of flammable and combustible materials in various areas of the designated centre, which posed significant fire safety risks. The inspectors also identified various other fire safety issues during this inspection, which are detailed in the subsequent sections of this report.

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

## Capacity and capability

Overall, there were systems in place to ensure that the residents were provided with safe and appropriate care. However, the provider's oversight arrangements required improvement actions to ensure full compliance with fire precautions. Furthermore, the findings of this inspection are that the registered provider was not operating the centre in line with the registered statement of purpose.

This unannounced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended). The provider had submitted a registration renewal application to the office of the Chief Inspector, and this application was in progress.

The provider of Larissa Lodge Nursing Home is Mountain Lodge Nursing Home Limited. The provider has a clear management structure in place, and staff members were clear about their roles and to whom they report. The person in charge of the centre is a registered nurse with the appropriate experience and a post-registration management qualification as required by the regulations. The provider had also employed an assistant director of nursing (ADON) and a clinical nurse manager (CNM) to provide management support for the person in charge. In addition, the

two senior managers at the group level regularly provided managerial support for the staff and residents in this facility.

The provider had established quality assurance systems, which encompassed key-performance indicators (KPIs), accident and incident management systems, and an audit framework. The records indicated that the senior management team consistently reviewed the key performance indicators, incidents and accidents occurring within the centre, along with the outcomes of various clinical audits, and formulated action plans where necessary to enhance the quality and safety of care and services delivered to residents. Records of regular management and staff meetings indicated that the provider had also established effective communication channels to facilitate quality improvements within the centre. The provider had submitted a substantial number of safeguarding statutory notifications since the last inspection. The inspectors found that all these incidents were appropriately managed and escalated in line with the provider's own policies. The inspectors found that the provider had ensured that learnings were identified following a review of these incidents and that actions were being implemented.

The provider also engaged with their competent person to address the fire safety issues in this centre. However, the oversight of fire safety risks in this centre was found to be insufficient. As a result, the provider was required to take immediate action to address several fire safety risks the inspectors identified during this inspection. This is further detailed in later sections of this report.

The inspectors reviewed a sample of residents' contracts and found that there were two different contracts in use; those who joined the centre since September 2022 had one version of a contract of care while residents admitted before this date had an older version of the contract of care. The version of the contract in use since September 2022 referenced higher fees for additional services and did not include access to a group occupational therapy programme that was included in the older contracts.

Inspectors found that residents who had the older version of the contract were paying the same charges as those on the newer contracts, which was an increase on the fee set out in their contract. In addition, the contracts for these residents included access to occupational therapy sessions, which were no longer available in the centre. This is discussed under Regulation 9: Residents' rights and Regulation 24: Contract for the provision of services.

Additionally, in the absence of a schedule for physiotherapy and occupational therapy sessions, it was not clear how often the group physiotherapy and occupational therapy sessions were provided for residents despite the fact that these services were included in the daily service charge. The inspectors were informed that these therapy sessions were part of the centre's social care programme, in which physiotherapists, available two or three days every alternate week, prescribed the exercise sessions and delivered the programme with the assistance of an activity staff member who was a qualified personal trainer.

However, the inspectors were not assured that these therapies necessarily aligned with the residents' assessed needs, as a number of residents' care records reviewed by the inspectors did not include specialist recommendations from relevant physiotherapy professionals. Nor did this explanation provide any clarification with regard to access to occupational therapy services.

## Regulation 15: Staffing

The provider had kept the staffing resources of the centre under review, and the rosters reviewed on the day of inspection evidenced that there were two nurses on duty at all times in the centre. There were sufficient staff with appropriate knowledge and skill-mix to provide care and services for the residents in line with their assessed needs.

Judgment: Compliant

## Regulation 16: Training and staff development

The inspectors reviewed the training records maintained in this centre and found that the person in charge had ensured that staff had access to appropriate training relevant to their roles and responsibilities. The provider had a system to ensure staff were appropriately supervised in this centre.

Judgment: Compliant

## Regulation 19: Directory of residents

The inspectors reviewed the directory of residents and found that this record contained all of the required information outlined in part 3 of Schedule 3.

Judgment: Compliant

## Regulation 21: Records

The registered provider had ensured that the records set out in Schedules 2, 3 and 4 were kept in the designated centre in a safe and accessible format.

Judgment: Compliant

## Regulation 22: Insurance

The provider had an up-to-date contract of insurance against injury to residents and protection of residents' property.

Judgment: Compliant

## Regulation 23: Governance and management

The registered provider had failed to operate the centre in line with agreed resources and facilities in the statement of purpose, specifically:

- The provider had admitted one resident with high dependency care needs into a double-occupancy room designated for mobile residents with low to medium dependencies. The layout of this room was not appropriate to effectively meet the needs of residents with high dependency needs. In addition, such an admission did not comply with the contents of the provider's statement of purpose referenced in condition 1 of the provider's registration.

The fire safety management systems to provide assurance in respect of fire safety were insufficient. Inspectors identified two fire risks in respect of the inappropriate storage of flammable and combustible items in the centre. Two immediate action plans were issued to the provider on the day of the inspection. The provider had addressed these issues by the end of the inspection.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of residents' contracts the provider had agreed in writing with residents and found that they did not comply with the requirements of the regulations. For example;

- the terms relating to the services mentioned under the contracts included services that the residents are entitled to free of charge through the general medical services (GMS) scheme or through their entitlement under any other health entitlement. As a result, the residents were charged for additional services that they are entitled to avail of free of charge.

- contracts for some residents set out how the additional charges that residents were paying should include access to occupational therapy. However, residents did not have access to such a service, a term of their contract and a service they were paying for.
- there was no evidence on the day of the inspection that residents could avail of services available through the community services under the General Medical Services (GMS) scheme. Additionally, there was no evidence that the residents were enabled to make an informed decision and decline additional services offered by the provider that incur extra fees.
- the additional service charges for residents were increased in November 2022, and the provider had issued written notices to residents and their nominated family representatives regarding this change sixty days before the increased service charges came into effect in November 2022. However, while a copy of the notice was available in each resident's file, the inspectors were not assured that the provider had engaged with the residents or their nominated family representatives regarding these increased fees, which would allow them to consider the impact of the changes to their contracts. For instance, there was no record of direct engagement with each resident or their family, nor were the changes discussed during resident meetings. In the absence of such engagement, it was not clear that residents were supported to make informed choices regarding their financial obligations and overall care arrangements.
- the inspectors found that four residents were not afforded all of the additional services for which they were charged for on a monthly basis; for example, group exercise sessions.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. Monitoring notifications and quarterly reports were submitted within the time frames specified by the regulations.

Judgment: Compliant

## Quality and safety

The inspectors observed that overall, residents were supported and encouraged to enjoy a good quality of life. However, the fire precautions in the centre required improvement to ensure compliance with the regulations. Additionally, action was

required to ensure that the residents were provided with an activities programme in line with agreed contracts of care.

Residents' clinical and risk assessments were undertaken using a variety of validated tools, and care plans were developed following these assessments. Care planning documentation was available for each resident in the centre. A sample of care plans viewed by the inspectors were generally comprehensive and person-centred. Residents' care plans were generally sufficiently detailed to guide staff in the provision of person-centred care delivery. The inspectors observed that the provider had arrangements in place to refer to community services, such as occupational therapy and physiotherapy service. In addition, records showed timely access to in-house physiotherapy support was arranged by the registered provider where required.

Four residents told inspectors that they received good care and support from the staff. The activities programmes took place in the centre as scheduled on the day of inspection, and one resident told the inspectors that they could choose how they spent their day. However, the inspectors were not assured that four residents were afforded sufficient opportunities to engage in meaningful activities that aligned with their individual preferences.

Records provided showed that approximately twenty out of sixty residents attended physiotherapy group sessions in this centre between September and November 2024. The management team also advised that those residents who could not attend group exercise sessions were offered one-on-one exercise sessions. However, a review of the records of a sample of residents who did not attend group physiotherapy sessions between September and November 2024 found that some residents did not receive any therapy sessions during the period under review. Additionally, the inspectors found that healthcare assistants or activity staff, rather than a physiotherapist or occupational therapist, facilitated regular individualised physical therapy sessions, such as structured walking programmes and softball exercises.

Regular residents' meetings were held, and a range of topics were discussed regarding the organisation of this centre. Residents' meeting records and feedback questionnaires indicated that they were generally satisfied with the care and services provided to them. However, there was no evidence that the registered provider’s withdrawal of occupational group therapy sessions or the changes to the fees for additional services had been discussed and agreed with residents. This is further discussed under Regulation 9: Residents Rights.

Residents have access to television, radio and newspapers in this centre.

The centre's notice boards contained additional information for residents, such as a resident information guide and details regarding the arrangements for making complaints and advocacy services. The inspectors also observed that the provider had engaged extensively with advocacy services and the national provider to assist a resident who had expressed a desire to reside in their own home. The inspectors found that the provider had developed appropriate discharge plans to facilitate this.

The centre's premises were generally well-maintained. While inspectors acknowledged that there was a refurbishment plan for residents' bedrooms in place, seven residents in the centre lacked adequate storage facilities to store their personal possessions. This is further discussed under Regulation 17: Premises.

The inspectors identified various fire safety risks during this inspection and found that the provider's processes to identify and manage fire safety risks were ineffective. These risks were in regards to inappropriate storage practices in relation to flammable items in a number of areas, maintaining appropriate means of escape, the existing fire evacuation strategy was not reflective of the existing environment in regards to compartmentation, and simulated fire drills were not available for the largest compartment of up to 12 residents. The location of the compartment and sub-compartment boundaries is paramount to ensure that when residents are moved to a place of temporary safety from a fire, they remain safe from the spread of smoke or fire before moving on to the next compartment. Therefore, the inspectors were not assured that adequate arrangements were in place to evacuate, where necessary, all persons in the event of a fire. Other concerns were identified in regard to the fire doors, emergency directional signage and lighting, fire precautions, and some of the resident's personal emergency evacuation plans (PEEPS) required a review. These and other fire safety concerns are detailed further under Regulation 28: Fire Precautions.

## Regulation 17: Premises

The registered provider did not ensure that the premises of this designated centre are appropriate to the needs of the residents and in accordance with the statement of purpose prepared under Regulation 3.

The centre's premises did not conform to all of the matters set out in Schedule 6 of the regulations. For example:

- The layout and design of two twin-occupancy rooms required review to ensure that each resident had sufficient space to ensure their privacy needs were adhered to and that they could move freely within their bedspace.
- The inspectors found that one of the bed spaces in each of two twin rooms lacked sufficient space for residents to use large assistive equipment, such as a full-body hoist, without encroaching on the neighbouring resident's bed space. The inspectors observed staff manoeuvring a full body hoist for a simulated resident in these rooms and found that the layout of these bedspaces did not facilitate the use of a full body hoist and that these rooms were not suitable for the needs of residents with higher dependency needs who required such devices. Consequently, inspectors were not assured that the residents in these rooms could perform personal activities privately while other residents required large assistive equipment.
- The inspectors found that the residents in two twin-occupancy rooms and two single-occupancy rooms did not have adequate storage facilities to store their

personal possessions. For example, seven residents in these rooms were found keeping their personal belongings, such as photo albums, behind their bedheads due to lack of sufficient storage.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

It is acknowledged that the provider carried out fire safety work at the centre prior to this inspection. Final sign-off for the completion of all works as identified in the provider's fire safety risk assessment dated September 2024 was required.

Notwithstanding this, the registered provider had failed to meet the regulatory requirements on fire precautions in some areas, and significant improvements were required by the provider in other areas to ensure adequate precautions against the risk of fire in the centre.

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- The inspectors observed a large quantity of flammable and combustible items such as cardboard boxes, paper and building materials in a boiler room and a water tank room. The room was found to be untidy and used as a storage room in an inappropriate manner. In addition, in two separate internal electrical storage areas, the inspectors observed the storage of items directly underneath a large existing electrical panel. These were highlighted on the day, and immediate actions were issued to address the risks, which were completed by the end of the inspection.
- The location of the fire assembly points required a review. An assembly point was located in a parking space and was not delineated to prevent the car parking space from becoming occupied. Furthermore, this area was not large enough for residents to gather due to the impact of the car parking area.

The provider needed to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. For example:

- An emergency directional signage was not illuminated at an internal final fire exit. Externally, there was a lack of emergency lighting at a fire assembly point and in some minor areas along external evacuation paths, which led to the fire assembly points. This required a review by a competent person to ensure safe evacuation away from all external fire exits to the designated fire assembly points during the hours of darkness.

Appropriate arrangements for the maintenance of fire equipment, the means of escape and the building fabric were not in place. For example:

- In an enclosed garden, the inspectors observed the use of a key-coded padlock used to secure a set of external gates. Some staff, when asked, were unsure of the code needed to release the padlock or where the code was documented. As a result, appropriate arrangements to maintain a clear means of escape were not in place. This created a potential risk for staff and residents to become trapped in the garden. This was brought to the attention of staff on the day, and an immediate action was issued to address the fire risk. Furthermore, the front fire door exit was fitted with a key-lock mechanism. All fire exit doors are required to be readily openable to ensure instant egress in the event of a fire.
- An up-to-date servicing and maintenance certificate for fire extinguishers was not available on the day of the inspection. As a result, the inspectors could not be assured the fire extinguishers were being appropriately serviced as required.
- The inspectors noted several areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures. These areas were identified in a dayroom, a laundry, a boiler room, a store room and a sluice room.

Arrangements for containment of fire in the event of a fire emergency in the centre were not adequate to facilitate progressive horizontal evacuation. For example:

- There was a lack of assurance in respect of the ability of a selection of fire doors and glazing to prevent the spread of smoke and fire. A number of bedroom fire doors had large gaps between the frame and the door leaf and at the threshold. Some storerooms and sluice room fire doors were missing door closers, were partially missing smoke seals or did not appear to meet the criteria for a fire door.
- The majority of 30 and 60-minute fire-rated cross-corridor fire doors appeared to have been modified with vision panels. The inspectors were not assured of the fire rating of the glazing in the door leafs as a fire-rated stamp could not be found. Furthermore, the inspectors could not be assured if the modifications had affected the integrity of the fire door assembly.
- In a laundry, a fire door was indicated by a door tag to be a 30-minute fire-rated door; however, as this is a high-risk room, a 60-minute fire-rated door was required for this room.
- Due to the varying degrees of deficiencies found in a number of fire doors and glazing elements throughout the centre, a review by a competent person is required to be carried out.

The provider failed to provide adequate arrangements for evacuating all persons in the designated centre and the safe placement of residents in the event of a fire emergency. For example:

- Personal emergency evacuation plans (PEEPS) were in place but required a review for one resident. For example, a record for one resident indicated only one staff member was required to assist in an evacuation, and a ski-sheet was required for an evacuation aid. As the use of a ski-sheet would take two staff members, the record did not accurately reflect these residents' evacuation requirements.
- During the inspection, it was confirmed by staff that there were no compartmentation boundaries to an area that had been believed to be a sub-compartment. As a result, a larger compartment existed than previously stated by the provider on the day of the inspection. While fire evacuation drills were taking place, a drill for the actual largest compartment based on night-time staffing levels was not available. Staff, when asked, were under the impression that every cross-corridor door was a fire compartment boundary. The evacuation policy stated for staff to move residents to the second set of fire doors, but this would not result in residents being moved into a fire compartment. This had significant consequences for the evacuation design strategy of the centre, which is based on progressive horizontal evacuation. Furthermore, the evacuation procedure did not clearly state who would meet the fire brigade upon arrival in a fire emergency.
- As a result of the compartments and perceived sub-compartments or lack of them, a review of staff fire training, fire evacuation policy, evacuation floor plans, assessment of residents' location along with dependency needs and fire drills based on the actual largest compartment of 12 was required. The inspectors observed that one compartment was fully occupied by 12 residents and 11 out of 12 beds were occupied in the second compartment. On the day of the inspection, two drills based on the two of the largest compartment were requested. The provider submitted only one drill completed after the inspection.

The displayed procedures to be followed in the event of a fire required a review by the provider. For example:

- The inspectors noted a lack of fire compartments and zoned floor plans on display at the main fire detection alarm system panel.

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

The residents had a care plan in place, and the care plans were person-centred. The care plans were found to be revised following consultation with the residents concerned and, where appropriate, the residents' families.

Judgment: Compliant

## Regulation 6: Health care

Residents' health and well-being were promoted, and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as physiotherapy, dietitians and speech and language, as required.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

Staff who spoke with the inspectors showed a clear commitment to respond to responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) in a manner that is not restrictive. The centre was working towards a restraint-free environment. Care files indicated that appropriate assessments were carried out and alternatives had been trialled before recommending the use of restraints.

Judgment: Compliant

## Regulation 8: Protection

The provider had systems in place to ensure that residents were safeguarded from risk of abuse.The procedures to be followed by staff were set out in the centre's policies and in individual residents' safeguarding plans. These measures included arrangements to ensure all incidents, allegations or suspicions of abuse were addressed and managed appropriately to ensure residents were safeguarded at all times. All staff were facilitated to and had completed training on safeguarding residents from abuse, and staff who spoke with the inspectors demonstrated knowledge in appropriately responding to and managing safeguarding incidents.

Judgment: Compliant

## Regulation 9: Residents' rights

Inspectors were not assured that residents' rights were being upheld at all times, as evidenced by:

- The inspectors found that four residents were not afforded sufficient opportunities to engage in meaningful activities that aligned with their individual preferences. For example, the care records of four residents indicated that they were not encouraged or afforded opportunities to participate in meaningful activities for approximately 25 to 30 days during the months of September, October, and November 2024, which was not in line with their individual preferences. This observation was further supported by feedback from two residents. For example, when asked about activities programmes, one resident said," I would love to take part in activities, but staff are busy, and sometimes they don't come near me", another resident told the inspectors that, "sometimes they (staff) come to me, but not every day, staff have work to do".

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and care plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Managing behaviour that is challenging | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Larissa Lodge Nursing Home OSV-0005791

## Inspection ID: MON-0041180

## Date of inspection: 27/11/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A review took place of the layout/dependency levels for twin rooms occupancy, an updated SOP was submitted the day after inspection, however the resident who was and is still accommodated in the room has expressed a preference to remain in situ. The resident will continue to occupy the room, with the second bed remaining unoccupied, until such time as a change in the resident's needs or preferences necessitates a review. This arrangement ensures the resident's privacy, dignity, and compliance with regulatory requirements.<br><br>A full rewiew of storage of combustibles and flammable items will be completed and all are now stored appropriately. The Maintenance person will conduct regular checks to ensure that combustible items are stored safely. | |
| Regulation 24: Contract for the provision of services | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:<br>The provider acknowledges the inspectors' feedback regarding residents' contracts. We wish to clarify and respond as follows:<br>1. Contracts of Care and Transparency:<br>o All residents have a signed contract of care in place.<br>o At the pre-admission stage, fees and services are explained in detail to prospective residents and/or their representatives. This includes a full breakdown of services covered | |

under the Nursing Home Support Scheme (Fair Deal) and services charged as Additional Service Charges.
o The Larissa Lodge contract outlines the services provided by the nursing home and their associated costs, this is irrespective of services provided by alternative providers which our centre cannot rely upon.
2. Additional Service Charges:
o Certain services necessary to meet residents' care needs and ensure regulatory compliance are not funded by the State under the Nursing Home Support Scheme.
o To comply with legislative requirements and ensure residents receive care that meets their individual needs and statutory standards, these services are itemised and charged as Additional Service Charges in the Contract of Care, as outlined at the point of admission.
o Participation in these services is always at the discretion of the resident, though the nursing home has a duty of care to ensure their availability and accessibility.
3. Occupational Therapy (OT) and Physiotherapy Services:
o Some historical contracts referenced OT services. When OT was unavailable on-site, this was explained in writing to residents/representatives. To mitigate this, physiotherapy provision was increased, and additional supports are provided. Whilst physiotherapy and occupational therapy are two distinctively different therapies, the Registered Provider took the approach to increase physiotherapy as a measure to enhance quality and reduce risk in the delivery of care.
o Residents are referred to services under the GMS scheme where clinically indicated; however, such services are not consistently available through the state system (including OT & Physiotherapy services) Where available, residents are supported to access them.
o No resident has raised objections or complaints regarding this arrangement.
4. Resident and Family Engagement:
o To support this, meetings have been conducted with service users and families to gather information and input to guide service delivery.
5. Contractual Position:
o Residents/representatives were informed of the unavailability of certain services and of alternative provisions.
o We remain committed to ensuring contracts are clear, transparent, and compliant with legislation. Resources have been allocated to ensure the availability of the services listed in the contracts, recognising that residents may choose whether or not to avail of them.

1. The Registered Provider will continue to confirm that information on services and fees continues to be given at pre-admission stage
2. The Registered Provider will continue to ensure residents are consistently informed of state service referral pathways (e.g. GMS)
3. The Registered Provider will monitor for and respond to any resident/representative concerns about contracts or services and manage these inline with the centres complaints policy (to date no such concerns have been raised).
4. Part 7 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) requires that a registered provider agrees a written care contract with each resident on admission to the nursing home. The contract sets out the services to be provided to the resident and the fees to be charged in respect of those services, in accordance with the Regulations. In this context, and as reflected in the Ministerial response to a Parliamentary Question, residents should not be charged fees other than those provided for within the contract of care. The Contract of

Care for Larissa Lodge has been reviewed and prepared to ensure alignment with these regulatory requirements, including clarity and transparency in relation to services provided and fees applicable.
5. Where a material change to the services provided results in a change to the terms of the Contract of Care, any such variation will be addressed with service users in accordance with the principles of contract law.
6. This does not apply to changes in individual residents' assessed needs or the care responses required to meet those needs, which are managed through assessment and care planning in accordance with the Regulations.

The provider is satisfied that residents are supported to exercise choice in relation to services, including retaining access to services available through the General Medical Services (GMS) scheme (Records show 35 physiotherapy and 12 occupational therapy referrals to the HSE between September–November 2024), and that they are not obliged to avail of additional services offered by the provider which may incur extra fees. The contract of care, as required under Regulation 24 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, clearly outlines residents' entitlements, Additional Service Charge (ASC) inclusions, and details of any other services which a resident may choose to avail of but which are not covered by the Nursing Homes Support Scheme or other health entitlements. The Registered Provider and Person in Charge (PIC) will continue to ensure that contracts of care are transparent, fully compliant with Regulation 24, and that residents' rights to choice, access to GMS services, and the ability to decline additional services are respected in line with Regulation 9.
• The provider acknowledges the inspectors' comments. In accordance with Regulation 24 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, written notice of the change in Additional Service Charges was issued to all residents and/or their nominated representatives more than 60 days in advance of the changes taking effect. A copy of this letter is maintained on the relevant resident's file as evidence of compliance and as noted by the inspector. The provider is satisfied that this process met the regulatory requirement. The notice issued clearly outlined the details of the changes and included the contact information, with an explicit invitation for residents and/or their representatives to make contact should they have any queries or wish to discuss the matter further. This ensured that residents and representatives were fully informed and afforded the opportunity to seek clarification prior to implementation. The Registered Provider and Person in Charge (PIC) will continue to follow this established process of written notification, ensuring that residents and/or their representatives are provided with clear information, adequate notice, and accessible channels to raise questions or seek clarification in relation to any future changes
• The provider acknowledges the inspectors' observation regarding occupational therapy. Prior to November 2022, the contract of care included occupational therapy as part of the Additional Service Charge. Due to a national shortage of occupational therapists, the external provider was unable to provide regular sessions in 2023.To ensure continuity of therapeutic input, the provider arranged for additional physiotherapy sessions as a substitution. Whilst physiotherapy and occupational therapy are two distinctively different therapies, the Registered Provider took the approach to increase physiotherapy as a measure to enhance quality and reduce risk in the delivery of care. Residents and/or their nominated representatives were informed in writing of this change on 31 October

2023. No objections were received, and the provider is satisfied that the substitution provided therapeutic benefit and maintained value for residents. The Registered Provider and Person in Charge (PIC) will continue to review the availability of contracted services and ensure that residents and/or their representatives are informed in advance of any changes, with clear communication maintained in line with Regulation 24.

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 17: Premises | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:
A review took place of the layout/dependency levels for twin rooms occupancy, an updated SOP was submitted the day after inspection, however the resident who was and is still accommodated in the room has expressed a preference to remain in situ. The resident will continue to occupy the room, with the second bed remaining unoccupied, until such time as a change in the resident's needs or preferences necessitates a review. This arrangement ensures the resident's privacy, dignity, and compliance with regulatory requirements.

The Person in Charge (PIC) will ensure that residents accommodated in twin rooms are subject to regular review to confirm that their individual care needs and preferences are appropriately met in this setting and inline with the Statement of Purpose.
The provider acknowledges the inspectors' observation regarding the storage of personal items in two double-occupancy rooms and two single-occupancy rooms. It is noted that some residents choose to display items such as photo albums behind their bedheads as a matter of personal preference rather than due to a lack of storage facilities. The one resident who requested additional storage has since been accommodated.
The Registered Provider and Person in Charge (PIC) are satisfied that adequate storage is available and will continue to respond to individual residents' requests for additional storage, insofar as is reasonably practicable. Ongoing monitoring will take place to ensure that residents' needs and preferences in relation to the storage of personal possessions are met.
A review took place of the layout/dependency levels for twin rooms occupancy, an updated SOP was submitted the day after inspection, however the resident who was and is still accommodated in the room has expressed a preference to remain in situ. The resident will continue to occupy the room, with the second bed remaining unoccupied, until such time as a change in the resident's needs or preferences necessitates a review. This arrangement ensures the resident's privacy, dignity, and compliance with regulatory requirements. The Person in Charge (PIC) will ensure that residents accommodated in twin rooms are subject to regular review to confirm that their individual care needs and preferences are appropriately met in this setting and in line with the Statement of Purpose.

| Regulation 28: Fire precautions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All combustible items removed immediately on the day of inspection.
• Boiler and water tank rooms cleared.
• Electrical storage areas cleared.
• Regular environmental walk-through checks by Maintenance Personnel.
• The Registered Provider will request a review of the Fire Assembly point by a competent person to identify a more appropriate Fire Assembly point and if required will also request a review of the external lighting.
• The emergency directional signage at the internal fire exit was repaired.
• A system has been put in place to ensure that all staff are aware of and have access to the key coded lock for external gates. The Front fire door lock has panic-bar release mechanism in place linked to fire panel, which activates in the event of a fire/ need for evacuation.
• The fire extinguisher service record was complete & available for inspection. The Registered Provider will continue to ensure that fire extinguishers are services as per requirements.
• The Fire sealing measures have been addressed in the identified areas.
• The centre has been constructed and is certified in line with planning, building and fire regulations. In addition, the Registered Provider will engage a competent person to complete a full review of defective doors, the cross-corridor fire doors, and the laundry room door and following this an action plan put in place to repair/ replace where required.
• The one PEEP identified was rectified on the day of inspection. All PEEPs are reviewed and updated to reflect accurate staffing and equipment needs.
• A Night-time drill as requested was completed for the largest compartment and records submitted to HIQA the day after inspection.
• Compartmentation plan confirmed by competent person; evacuation zones outlined accordingly, and duplicate plans have been placed at each nursing station for staff and fire service use to ensure safe horizontal evacuation.
• The Fire Procedure outlines that the Nurse in Charge will meet the Fire Brigade the event of a fire emergency.
• Fire huddles done with staff to assure roles and responsibilities understood and staff training will include updated compartmentalisation evacuation.
• The Fire Management Policy will be updated to reflect these changes.
• The fire compartments and floor plans are on display at the main fire detection alarm system panel.
• A fire drill will be completed and submitted on 16.01.26
• Fire certificates will be submitted 9.01.26
• A competent person will sign off fire works as identified by the Fire Safety Risk Assessment 31.01.26

| Regulation 9: Residents' rights | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The structured, documented activities programme will be reviewed, including both group and one-to-one options, to ensure that as far as is reasonably practicable these are tailored to resident interests and abilities.

• On-the-spot records and clarification were provided by the ADON, who retrieved and presented the relevant participation records to the inspectors during the inspection. For the two residents referenced, the inspection report itself (page 5) notes that they had "expressed a preference for not participating, opting instead to remain in their individual rooms." The provider is satisfied that residents' rights to make choices regarding participation in activities are respected, and that their decisions are known. The Person in Charge (PIC) will ensure that activity records continue to accurately reflect residents' preferences and participation, and that residents are consistently encouraged and supported to engage in activities of interest to them, while respecting their right to decline. The PIC will continue to complete resident satisfaction surveys, which do include the subject of activities, rights and preferences.

## 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 |
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| Regulation 17(1) | The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3. | Substantially Compliant | Yellow | 30/11/2025 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Substantially Compliant | Yellow | 30/11/2025 |
| Regulation 23(a) | The registered provider shall ensure that the designated centre has sufficient resources to | Not Compliant | Orange | 30/10/2025 |

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| | ensure the effective delivery of care in accordance with the statement of purpose. | | | |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 30/10/2025 |
| Regulation 24(2)(d) | The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the resident is not entitled under any other health entitlement. | Substantially Compliant | Yellow | 30/11/2025 |
| Regulation 28(1)(a) | The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, | Not Compliant | Orange | 30/09/2025 |

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| | suitable building services, and suitable bedding and furnishings. | | | |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Substantially Compliant | Yellow | 30/09/2025 |
| Regulation 28(1)(c)(i) | The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services. | Not Compliant | Orange | 30/01/2026 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 30/01/2026 |
| Regulation 28(2)(iv) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents. | Not Compliant | Orange | 30/10/2025 |
| Regulation 28(3) | The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre. | Substantially Compliant | Yellow | 28/09/2025 |

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| Regulation 9(2)(b) | The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities. | Substantially Compliant | Yellow | 30/10/2025 |