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:	Ave Maria Nursing Home
Name of provider:	Cummer Care Limited
Address of centre:	Tooreen, Ballyhaunis, Mayo
Type of inspection:	Unannounced
Date of inspection:	12 June 2025
Centre ID:	OSV-0000315
Fieldwork ID:	MON-0047407

About the designated centre

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

Ave Maria Nursing Home is a purpose built single storey building, registered to provide care for 41 residents. The designated centre is family run and is located in a small country village. The centre is surrounded by mature gardens some of which are laid out with seating areas and vegetable gardens. The provider's cat and dog visit the centre every day and are enjoyed by the residents. All resident bedrooms are well laid out and have an en-suite bathroom facility. The centre provides care to residents over 65 years with chronic illness, residents living with dementia and those requiring end of life care. The philosophy of care at Ave Maria Nursing Home is to create a home away from home environment, to deliver person centred care to each individual resident, in a comfortable, safe environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

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 12 June 2025	18:00hrs to 21:00hrs	Helena Budzicz	Lead
Friday 13 June 2025	09:00hrs to 16:15hrs	Helena Budzicz	Lead
Thursday 12 June 2025	18:00hrs to 21:00hrs	Michael Dunne	Support
Friday 13 June 2025	09:00hrs to 16:15hrs	Michael Dunne	Support

What residents told us and what inspectors observed

Residents told inspectors that they were happy and content living in the designated centre. Residents said that staff were kind and caring, and that they felt safe and secure in the designated centre. The inspectors observed positive interactions between staff and residents throughout the inspection. Several residents told the inspectors " I have no concerns" while another resident said " I get help when I need it". The inspectors also spoke with visitors who attended the centre, and without exception, they all said that "they were happy with the support provided to their loved ones".

Notwithstanding this positive feedback, inspectors found several areas of service provision where actions were required to improve the care and welfare of residents. Inspectors found repeated non-compliance with several key regulations that underpin residents' care. These findings are discussed further under the relevant regulations in this report.

Upon arrival on the evening of the first day, the inspectors completed the sign-in process and were met by two directors who work in the centre. The inspectors explained the purpose of the inspection and informed the provider that they would return to complete the inspection the following day. On the second day of the inspection, another director of the provider entity attended the centre, and the inspectors provided them with information regarding the purpose of the inspection. Following the introductory meetings on both days, the inspectors commenced walkabouts of the designated centre where they had opportunities to meet residents, and staff as they prepared to retire on the first day, and to begin their routines on the second day.

There were 35 residents living in the centre on the first day of the inspection. The centre received a resident admission on the second day of the inspection, increasing the occupancy level to 36.

On the evening of the first day, inspectors observed that staff were busy providing care and support to residents who wished to retire to their bedrooms or to other areas of the designated centre. Several residents were observed spending time in the seated area near the centre's reception and were found interacting and discussing news with staff and other residents. Residents appeared relaxed and confirmed that they could go to bed and get up when they wanted.

Inspectors spoke with several staff on the evening, and from these discussions, it was evident that staff were familiar with the assessed needs of the residents. Communication between staff and residents was based on respect for the individual and was adapted for the specific needs of the residents. Some residents required additional support with their communication due to a cognitive impairment, and this was provided by staff in a supportive, person-centred manner.

A review of the menu options available for residents on the first day of the inspection included lamb stew and chicken burgers. The food available for tea service consisted of black and white pudding, french toast, and beans. Other options available on the menu included creamed rice, salads and cake. Inspectors observed staff preparing and serving supper to residents, which included sandwiches, snacks and liquid refreshments. Residents told the inspectors that they enjoyed the food provided.

On the second day of the inspection, observations confirmed that residents were supported with their personal care requirements in a discreet and dignified manner. Staff were observed knocking on bedroom doors, announcing their arrival to residents when entering residents' bedrooms and were found to explain the purpose of their visit. Residents were encouraged and supported to attend the activities provided, which included a selection of board and ball games coordinated and led by a health care assistant. Some residents were observed watching televisions in their rooms, reading newspapers or receiving visitors throughout the day.

The inspectors met with the activity staff, who confirmed that the planned activities available on the day included a physio exercise session, ball games, jigsaws, bingo and music sessions. The inspectors noted that there was no activity schedule advertised in the centre to inform residents of what was available so that they could plan their day and make informed choices in respect of what they wished to attend; this is a recurring finding from previous inspections.

Residents were accommodated in single rooms with adjoining en-suite facilities, which included a sink, toilet, and shower facilities. Residents' rooms were tastefully decorated and personalised by residents according to their individual tastes. All residents' rooms observed on inspection were clean, of suitable size and contained storage facilities for residents to be able to store and access their personal belongings. However, inspectors noted that the capacity of some wardrobes appeared limited.

Residents had unrestricted access to all areas of the centre; however, two garden areas to the rear of the centre were not being used by residents. Neither of these areas was secure, nor did they contain any seating facilities for residents to use. This was brought to the attention of the provider on the day. Inspectors observed that although there was a smoking shelter available for residents to use, there were no fire safety measures in place to protect this facility, such as fire detection or a call-bell for residents to attract staff attention.

In contrast, seating facilities were available near the entrance to the centre, which the provider informed the inspectors that residents preferred to use. Throughout the two days of inspection, this area was not seen to be used by residents. There were sufficient numbers of communal spaces for residents to use, which included day rooms, dining rooms, a visitor room and a smoking room. On the whole, the centre was well-maintained; however, some storage and wear and tear concerns were identified and are discussed further under Regulation 17: Premises and Regulation 27: Infection Control.

Meal options available on the second day included a cod meal, an omelette, and fish fingers. While cold meats, salads and puddings were available later in the day. The inspectors noted that the residents were supported to eat their meals either in the dining room or a large communal room, in accordance with their preferences. When inspectors asked about the meal menu for the next day, they were informed that this is prepared by the provider on a day-to-day basis.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

This inspection found a significant decline in regulatory compliance, and that specific focus was now required by the provider to ensure that current management and oversight systems were effective in improving the quality of the service and to ensure that resources were made available to provide clinical support so that residents received a safe and appropriate service.

This was an unannounced risk inspection carried out by inspectors of social services over an evening and the following day to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 to 2025 (as amended). The inspectors also followed up on unsolicited information that had recently been received by the Chief Inspector of Social Services, specifically in relation to the governance and oversight of the designated centre, the delivery of clinical care, the monitoring of infection prevention and control, and the oversight of food and nutrition for the residents.

The findings of this inspection found these concerns to be validated. The particular areas of concern and relevant findings are discussed in more detail under the specific regulations namely in respect of the governance and management, person in charge, staffing, training and development, records and complaints, as well as the regulations pertaining to the quality and safety section including individual care plan and assessments, health care, food and nutrition, infection control, residents' rights and medication management. This meant that there was a significant risk to the residents living in this centre as the provider had not ensured that the services provided were safe, appropriate, consistent, and effectively monitored.

Ave Maria Nursing Home is owned and operated by Cummer Care Limited. The company has three directors. Inspectors identified that the management structure outlined in the designated centre's statement of purpose (SOP) was not in place. The provider had not ensured that there was a suitable person in charge who met the requirements of Regulation 14: Person in charge and provided leadership to the staff team, nor had they recruited for a vacant clinical care manager (CNM) post.

This meant that there was a significant lack of clinical expertise available in the designated centre to monitor the clinical care of the residents or to provide supervision and guidance to the nursing team. While the provider had submitted a notification identifying a replacement for the person in charge role, they had not submitted all of the required information to inform the assessment. There was a lack of clarity in respect of the reporting structures, and at the time of this inspection, no nursing staff were identified by the registered provider to lead the team and oversee the service provided. Furthermore, the provider was found to have admitted two residents to the designated centre without having a senior clinical oversight in place to fully review and manage these admissions.

Information governance systems reviewed did not provide assurance of effective service oversight. For example, governance and management meeting records did not contain sufficient information to indicate whether key aspects of the service were adequately monitored. The records that were made available for review did not evidence any analysis of clinical indicators, and consequently, there was no quality improvement action identified. There is further narrative regarding the lack of oversight of the service, which is detailed under Regulation 23: Governance and management.

Overall, the availability, maintenance and update of records to underpin and inform the quality of the service were not sufficient. This is described in more detail under Regulation 21: Records.

A review of staff records confirmed that the centre had undergone significant staff turnover since October 2024, with the provider having recruited 11 staff nurses, six health care assistants, and activity and housekeeping staff. Notwithstanding the gaps in managerial and leadership roles, at the time of this inspection, there was a full complement of staff nurses and care staff. Records confirmed that new staff had access to an induction programme and training relevant to their role. The staff had attended mandatory training, which included training related to fire safety, safeguarding, and manual handling. Staff also had access to additional training to inform their practice, which included infection prevention and control, medication management, cardio pulmonary resuscitation (CPR), responsive behaviour, and restrictive practice training.

The inspectors reviewed records relating to complaints and found that the designated centre had received one complaint since the last inspection. This complaint had been reviewed and processed in line with the centre's complaints policy.

Regulation 14: Persons in charge

At the time of this inspection, the provider did not ensure that there was a person in charge in place to meet the requirements of Regulation 14. A notification had been received from the provider identifying a new person in charge; however, not all of the prescribed information had been submitted to support this application. In

addition, the provider did not identify a person who could deputise in the absence of the person in charge.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider did not ensure that sufficient numbers of staff were available with the required skill-mix to meet the assessed needs of the residents in the designated centre. For example:

- There was no clinical nurse manager in post, in line with the whole-time equivalent (WTE) set out in the provider's statement of purpose (SOP).

Judgment: Substantially compliant

Regulation 16: Training and staff development

Despite a number of new staff recruited recently, there was no clinical support and oversight available on the day of the inspection to provide effective supervision for the staff team. A clinical nurse manager position (CNM) was vacant and there was no person in charge appointed. This meant that clinical supervision arrangements were not adequate to ensure that care was delivered according to residents' needs and conditions. This increased the risk to residents across several key areas of service provision related to care and welfare regulations, including Regulation 9: Residents' rights, Regulation 5: Individual assessment and care plan, Regulation 6: Health care, Regulation 27: Infection control, and Regulation 29: Medication management. For example, in the absence of effective supervision, institutional practices such as the use of shower lists to provide personal care to residents had developed.

Judgment: Not compliant

Regulation 21: Records

A review of records maintained by the registered provider found,

- A review of Schedule 2 records found that one staff member had only one written reference on file.

- There were gaps in the maintenance of cleaning records with no sign-off by senior staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that the designated centre was adequately resourced to ensure the effective delivery of care in line with the statement of purpose. For example:

- There was a diminished management structure in place as key senior clinical personnel had left and were not replaced. While a new person in charge had recently been appointed, the input from the provider for the person in charge was not sufficient to support them in their role.
- There was no Clinical nurse manager (CNM) as outlined in the staffing requirements in the Statement of Purpose, and there were no arrangements in place to deputise for the person in charge.

The management systems in place did not ensure the service was safe, appropriate and consistent. This was evidenced by:

- The oversight systems of staff supervision and training were not sufficiently robust to support staff in appropriately assessing and responding to residents' needs in a person-centred manner, promoting residents' rights, and their access to health care, and ensuring appropriate infection control and medication management practices.
- The management systems and oversight of the new admissions of residents to the centre require a review. Inspectors were informed by staff and observed that the pre-admission assessments for new residents were completed by staff nurses on duty over the phone, in the absence of senior clinical professionals. This posed a significant risk of inappropriate admissions.
- The management oversight of key clinical indicators of quality and safety of the care provided to the residents was not adequate. There was no analysis of this data, and therefore, no quality improvement plans. Management meeting records did not include sufficient detail to provide assurance of effective monitoring. The oversight of premises and overall environment to ensure it was in line with regulatory requirements and infection prevention and controls standards was insufficient, as it had failed to identify key concerns as further detailed under Regulation 17: Premises and Regulation 27: Infection control.
- Oversight and a review of the residents' nutritional needs revealed areas for improvement. During the inspection, a daily food menu was presented; however, it did not include options for modified diets. Additionally, there was no comprehensive food menu available, and proper nutritional analysis and

audits had not been conducted to ensure that the residents' nutritional needs were effectively met.
- The management of risks in the designated centre was not effective, which meant that not all risks were identified and appropriately mitigated. Known risks related to fire safety, infection prevention and control, or lack of clinical expertise did not have robust measures in place to mitigate the impact.
- There was no identified person assigned with overall responsibility and oversight for infection prevention and control (IPC) and antimicrobial stewardship in the centre.
- The oversight of medicine administration systems that were in place did not support safe medicine administration. While there were audits of medication management completed, they were not effective as they did not identify some of the medication errors found on this inspection. Where audits identified errors, there was no appropriate action taken in response. This is detailed under Regulation 29: Medicines and pharmaceutical services.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose (SOP) in place, which included the information set out in Schedule 1 of the regulations. However, this document required updating to accurately describe the availability of management support in the service. For example:

- The narrative in the statement of purpose regarding the number of clinical nurse managers (CNM) available to support the effective governance of the service, and those outlined in the centre's organisational structure, were not in alignment. The SOP identified that two CNMs were available, whereas the organisational structure indicated that only one CNM worked in the centre. There was no CNM in place on the day of inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of incidents involving residents that have occurred in the centre is maintained. Notifications and quarterly reports had been submitted to the office of the Chief Inspector of Social Services within the specified time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

Although there was a complaints policy and procedure in place and the records showed that complaints were managed in line with policy, the provider had not ensured that both the complaints officer and the review officers had received training in complaints management, in line with the requirements of this regulation.

Judgment: Substantially compliant

Quality and safety

Overall, residents appeared happy living in the centre, and many spoken with said they were content with the care they received. However, the quality and safety of the service being delivered to residents were being negatively impacted by the ineffective oversight of clinical care, combined with inadequate governance systems to identify and improve key areas of the service.

There were arrangements in place for residents to access a general practitioner (GP) of choice, as well as Psychiatry of later life and a variety of health and social care services, including dietitians, speech and language therapists (SALT) and tissue viability nursing (TVN) to provide support to residents' care if required. However, the review of medical records and speaking with staff members indicated that residents did not have regular in-person access to GP services. This is discussed under Regulation 6: Health care.

The inspectors reviewed a sample of the resident's assessments and care plans and found that the resident's nursing needs were not always being assessed within 48-hours following admission to the centre. A number of care plans reviewed did not ensure that information was consistently updated as residents' needs changed. This is further discussed under Regulation 5: Individual assessment and care plan.

While medication systems were in place and staff spoken with were knowledgeable of their regulatory responsibilities, inspectors noted that not all medicinal products were stored securely at the centre, and not all medications were administered in line with best practices as discussed under Regulation 29: Medicines and pharmaceutical services.

Residents expressed overall satisfaction with food, snacks and drinks. Residents had access to fresh drinking water. Choice was offered at all mealtimes, and adequate quantities of food and drink were provided. Food was freshly prepared and cooked on site. There was adequate supervision and assistance at mealtimes. However, some further improvements were required to ensure that the nutritional needs of residents were appropriately met.

Overall, the centre was found to be clean and warm throughout. Some good infection prevention and control measures were in place and monitored by the management of the centre. Further opportunities for improvement are discussed under Regulation 27: Infection control.

There was a safeguarding policy in place that set out the definitions of terms used, responsibilities for different staff roles, types of abuse and the procedure for reporting abuse when it was disclosed by a resident, reported by someone, or observed. The staff team had completed relevant training and were clear on what may be indicators of abuse and what to do if they were informed of or suspected abuse had occurred.

Although there was regular verbal interaction between the provider and residents, which was observed on a daily basis, formal residents' meetings were not held every two months, as outlined in the statement of purpose. This lack of structured communication posed a risk of missing opportunities to gather and address residents' feedback.

Regulation 11: Visits

There were no visiting restrictions in place during the inspection; visits and social outings were facilitated and encouraged. Friends and relatives were seen coming and going on both days of the inspection.

Judgment: Compliant

Regulation 17: Premises

A review of the premises found that the registered provider, having regard to the needs of the residents, did not provide premises which fully conformed to the matters set out in Schedule 6. For example:

- External spaces were not all well-maintained. Two external garden areas to the rear of the centre were unsuitable and unsafe for residents to use. Both garden areas were unsecured. One garden had a wall damaged by a storm earlier in the year, which had not been repaired. There were no seating facilities for residents in these two gardens.
- Flooring in a corridor was damaged and required repair to ensure it did not pose a safety risk.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy and procedure in place, which was reviewed in November 2024 and contained details regarding the identification of risk, the assessment of risk and the measures and controls in place to mitigate against known risks. The policy met all the requirements as set out under Regulation 26. The management and oversight of risks is discussed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 27: Infection control

The registered provider did not ensure that all procedures consistent with the National Standards for Infection Prevention and Control in Community Services (2018) published by the Authority were implemented. For example;

- There was a continued reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection (UTI). This was contrary to national guidelines, which advise that inappropriate use of dipstick testing can lead to unnecessary antibiotic prescribing, which does not benefit the resident, and may cause harm, including the development of antibiotic resistance. The inspectors were informed that all residents were prescribed antibiotics based on a urine dipstick result.
- An accurate record of residents with a history of multi-drug resistant organism (MDRO) colonisation (surveillance) was not maintained. This meant that staff were unable to monitor the trends in the development of antimicrobial resistance within the centre.
- An antimicrobial stewardship (AMS) practice was not in place to ensure that the volume of antibiotic use was monitored each month, which enabled easy trending.
- There was no person assigned with overall responsibility for infection prevention and control (IPC) and antimicrobial stewardship.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- There was a lack of understanding of the importance of segregation between clean and dirty processes. For example, a store room was seen to contain clinical boxes for urinary catheters and colonoscopy sets alongside a working toilet, pressure cushions, and an oxygen concentrator. Laundry skips were found in the communal bathrooms. This posed a risk of cross-contamination.
- Surfaces to door, door frames and hand rails were marked and scuffed, the cover of the cabinet underneath the hand-washing sink facility was peeling,

so effective cleaning could not be assured.A number of fabric seats were observed to be stained, torn and required more effective cleaning.
- The slings for residents' use were left hanging on the hoist after use. These were not always assigned for single residents' use, with residents' names, and inspectors observed that staff use them randomly among the residents. This posed a risk of cross-contamination and potential transmission of healthcare associated infections.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The medicine systems in place for dispensing, administration and storage required full review. For example:

- Inspectors observed that some medicinal products, including nutritional supplements, were stored in a communal dining room. These rooms were accessible to all residents, including visitors and other staff, not just registered nurses.
- Medicines, such as prescribed creams, eye drops, and antibiotics that were no longer required and had expired, were not segregated from other medicines and were not disposed of in line with national guidance.
- Inspectors observed hazardous medication administration practices which could pose a risk to the residents. For example, not all medication administered or not administered/ refused was signed by a registered nurse. Inspectors observed gaps in the administration records for both 12 pm and 6 pm medication rounds.
- Some medications with restricted time frames for use were missing open dates, creating a risk that these medications could be used beyond the safe administration guidelines.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure assessments and care planning documentation were in line with specified regulatory requirements as follows:

- While all five reviewed residents had a nutritional care plan in place, these plans were not updated to reflect residents' changing needs. This included important details such as the Malnutrition Universal Screening Tool (MUST) assessment scores and recommendations from dietitian evaluations. This meant that there was a lack of assurance that staff were aware of and were

implementing the current recommendations in respect of food and nutritional requirements.

- Care plans for the management of wounds included historical data that was no longer relevant, which could potentially cause confusion in the delivery of care to residents.
- Residents with a history of Multi-drug resistant organisms (MDRO) did not have an associated care plan in place, and this posed a risk of potential incorrect care delivery and spread of environmental and clinical MDRO colonisation.
- Care plans and assessments for residents who were re-admitted to the centre following a respite stay were not updated within 48-hours of admission to the centre. This meant that staff did not assess and thoroughly review whether the needs of the residents had changed since the last admission.

Judgment: Not compliant

Regulation 6: Health care

The residents had a general practitioner (GP) assigned upon their admission to the centre. However, the findings of this inspection are that the GP did not conduct in-person admissions for the residents. Additionally, there were no regular in-person reviews of the residents' conditions, including medication reviews, and these services were only accessed if a resident's condition changed or deteriorated in certain cases. Staff relied on communication via phones, emails, and out-of-hours medical services for medical support.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had systems in place to ensure residents were protected from abuse. These included safeguarding training and updates for all staff working in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found institutional practices that did not provide assurances that residents' rights to choice were respected. For example, personal care was provided to residents based on a shower list, which did not provide assurance that residents

would be provided person-centred care in line with their personal care preference, should they wish for personal care to be delivered on a different day.

In addition, while residents' meetings were due to be held every two months, inspectors found that no formal residents' meetings were held from August 2024 until February 2025. These arrangements did not ensure that residents were consulted and given opportunities to participate in the running of the centre.

Arrangements for the provision of activities over the weekend were not clear, as the activity coordinator did not cover weekends. The inspectors were informed that care assistants provided activities at the weekend in addition to their assigned role. However, there was no allocated time and no staff identified on the allocation roster to ensure that this arrangement was implemented in practice. This meant that the engagement of residents in meaningful occupational activities at the weekend did not always occur, and was contingent on the availability of staff, if they had time after completion of healthcare-related activities.

There was no planned activity schedule advertised in the designated centre available in a format accessible for those living with dementia and cognitive impairment. This meant that residents could not plan and make informed choices about what activities they would like to take part in, and that activities happened on an ad-hoc basis.

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	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ave Maria Nursing Home OSV-0000315

Inspection ID: MON-0047407

Date of inspection: 13/06/2025

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**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: To address the non-compliance identified under Regulation 14, the following actions are being taken: • A Person in Charge (PIC) has been appointed to ensure continuity of leadership and oversight of care. • A Clinical Nurse Manager (CNM) has been assigned to provide direct support to the interim PIC in managing daily operations and ensuring regulatory standards are consistently met. • The recruitment process for a permanent PIC is actively underway. Two suitable candidates have already been shortlisted, and interviews are set for 15/09/25 & 17/09/25. Permanent appointment is expected to be finalised by 10th October 2025 • In the interim, management will ensure that the appointed CNM and PIC receive ongoing governance support to maintain compliance with HIQA standards.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To achieve full compliance with Regulation 15, the following actions have been taken and are ongoing: • A Clinical Nurse Manager (CNM) was formally appointed on 13/06/25, providing additional leadership and clinical oversight to strengthen staffing governance. • The CNM supports the Person in Charge in ensuring that staffing levels, skill mix, and deployment of staff are appropriate to meet the assessed needs of residents at all times. • Ongoing monitoring of staffing rosters and resident dependency levels will continue to ensure that staffing arrangements remain responsive and in line with regulatory requirements.	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
To address the non-compliance identified under Regulation 16, the following measures have been taken and scheduled:
• A Clinical Nurse Manager (CNM) was appointed on 13/06/25, ensuring ongoing clinical supervision and oversight so that care is delivered in line with residents' assessed needs.
• Care Planning & Assessment:
o All nurses have completed care planning training delivered by private consultancy, facilitated by a former Person in Charge with over 10 years' experience using electronic system. 07/08/25
o Following this training, all care plans have been reviewed and updated by nursing staff and management. 30/08/25
o Further training on care planning and assessment has been scheduled for 20/10/25 to reinforce learning and ensure continuous improvement.
• Medication Management:
o All nurses successfully completed medication management training via online training by 15/09/25.
• Infection Prevention and Control (IPC):
o Infection control training for all staff has been scheduled for 18/10/25
o Two nurses are booked to complete a specialist IPC course on 13/10/25 to strengthen leadership and expertise in this area.
Staff Training and Accountability:
• Refresher training has been provided to all care staff on person-centred care, dignity, and residents' rights, emphasising choice, flexibility, and respect. 20/11/25
• Supervisory spot checks are carried out by the Person in Charge (PIC) and Clinical Nurse Manager (CNM) to ensure personal care is delivered in line with residents' wishes, with findings documented and reviewed. 01/08/25
• We have sourced a private consultancy to assist and support in supervision of the clinical governance in our center. First visit will be from the 7/10/25-9/10/25 of October – and continuous every two weeks untill 1/12/25 when it will be reviewed

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
To address the non-compliance identified under Regulation 23, the following actions have been implemented:
• Staff Records and Induction:
o All staff records have been updated to ensure compliance with regulatory requirements. 30/08/25
o A new induction checklist has been introduced and added to staff files. This ensures that all mandatory information and documentation are consistently captured, verified and maintained. 30/08/25
• Housekeeping and Cleaning Oversight:

o A cleaning schedule has been embedded into the electronic system, enabling housekeeping staff to maintain live records as they progress through rooms and areas. 10/09/25
o Weekly management reports are generated directly from electronic system, providing oversight, accountability, and evidence of compliance with infection prevention and control standards. 17/09/25

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To achieve full compliance with Regulation 23, the following actions have been taken and are ongoing:

Management Structure and Resourcing
• An Person in Charge (PIC) has been appointed to ensure continuity of leadership.
• A Clinical Nurse Manager (CNM) was appointed on 13/06/25, the day after the inspection.
• Recruitment is ongoing, with interviews in progress for a full-time PIC to provide permanent stability in the management structure.
• Interim deputising arrangements are in place to ensure cover in the absence of the PIC.
• We have sourced a private consultancy to assist and support in supervision of the clinical governance in our center. First visit will be from the 7/10/25-9/10/25 of October – and continuous every two weeks untill 1/12/25 when it will be reviewed

Staff Supervision and Training Oversight
• Structured staff supervision, with new CNM appointed
• A training matrix is in place to track mandatory and specialist training.
• Two nurses are booked to complete IPC training courses in 13/10/25 to strengthen clinical expertise and oversight.
• We have sourced a private consultancy to assist and support in supervision of the clinical governance in our center. First visit will be from the 7/10/25-9/10/25 of October – and continuous every two weeks untill 1/12/25 when it will be reviewed
Pre-Admission Assessments
• All preadmission assessments are now completed directly by management or senior clinical staff, not by staff nurses over the phone. 15/06/25
• A preadmission review meeting is held before acceptance to ensure appropriateness of placement. 15/06/25
Clinical Oversight and Quality Indicators
• A new auditing tool has been implemented through the electronic system. 16/09/25
• Audits are scheduled every three months and have been entered into the management diary.
• Clinical governance meetings now document detailed analysis, trends, and agreed actions.
Environmental Oversight

• Regular environmental checks have been implemented to ensure compliance with infection control and premises requirements.
• A maintenance upgrade schedule has been established for every six months, with works brought forward if issues are identified. 01/10/25
Nutritional Oversight
• Menus have been submitted to a dietitian for review and auditing, feedback received.
• Dietician feedback has been positive, and all menus are now meeting nutritional needs.
• New menus have been created to provide suitable options for residents requiring modified diets.
Risk Management
• The risk register is being reviewed and updated to reflect all known risks, including infection prevention, fire safety, and clinical care. 10/10/25
• Risks are now formally reviewed at monthly management meetings.
Infection Prevention and Control (IPC) and Antimicrobial Stewardship
• Two designated nurse has been assigned to Complete IPC course. Starts 13/10/25
• Once completed their role will include responsibility for IPC audits, and compliance monitoring.
• Appointment of a clinical lead to oversee antimicrobial stewardship. (PIC)
Medicines Management Oversight
• The medicines auditing process has been reviewed and strengthened. 15/09/25
• Audit tools now include follow-up actions and accountability.
• Spot-check audits are carried out weekly by management in addition to quarterly audits.
• Development and maintenance of an accurate, up-to-date surveillance log of residents with a history of MDRO colonization, 30/09/25
• Monthly review of surveillance data to identify trends and guide infection prevention strategies. 30/09/25

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
To achieve full compliance with Regulation 3, the following actions are being taken:
• The Statement of Purpose is currently under review and is in the process of being updated.
• Additional information is being incorporated to ensure it reflects the full scope of services provided and the day-to-day running of the centre.
• All relevant sections are being revised to ensure accuracy, transparency, and compliance with Schedule 1 requirements.
• The updated Statement of Purpose will be communicated to staff and made readily available to residents and their representatives by 30/10/25

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
To achieve full compliance with Regulation 34, the following actions are being implemented:
• Training has been scheduled for all Directors, Management, the Complaints Officer, and Review Officers on 16/09/25 by training company.
• This training will ensure that all individuals involved in the complaints process have a clear and consistent understanding of their roles, responsibilities, and the regulatory requirements governing complaints handling.
• The training will also reinforce the importance of transparency, timely resolution, effective communication with complainants, and accurate record-keeping.
• Following the training, the complaints procedure will be reviewed and updated where necessary to ensure that it continues to meet HIQA standards and reflects best practice.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To achieve full compliance with Regulation 17, the following actions have been undertaken and scheduled:
• External Environment: All external gardens have been upgraded, with repairs completed to perimeter fencing and new outdoor seating installed to enhance safety, accessibility, and resident comfort. Completed 18/07/25
• Flooring Works: Replacement of flooring in the areas identified during inspection has been booked for 03/10/25. These works will address the outstanding issues and ensure a safe, well-maintained environment for residents, staff, and visitors.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
To address the non-compliance identified under Regulation 27, the following actions are being taken:

Clinical Practice – Urinary Tract Infection (UTI) Diagnosis
• The practice of relying solely on dipstick urinalysis for diagnosing UTIs has been discontinued with immediate effect.
• Evidence-based diagnostic protocols, in line with national guidelines, have been adopted. These protocols are now laminated and clearly displayed at the nurses' station

for staff reference. 18/08/25
• Targeted staff education sessions have been delivered by the Person in Charge (PIC) to all nursing staff, focusing on correct assessment procedures and the reduction of unnecessary antibiotic prescribing.
Surveillance of Multi-Drug Resistant Organisms (MDROs)
• Development and maintenance of an accurate, up-to-date surveillance log of residents with a history of MDRO colonization, 30/09/25
• Monthly review of surveillance data to identify trends and guide infection prevention strategies.

Antimicrobial Stewardship (AMS)
• Appointment of a clinical lead to oversee antimicrobial stewardship.
• Introduction of a monthly audit system to monitor the volume and patterns of antibiotic use.
• Findings from AMS audits will be reported to the governance team and used to inform continuous quality improvement.
Governance and Responsibility
• A designated Infection Prevention and Control (IPC) persons has been assigned with course starting 13/10/25
• This role includes oversight of compliance with national standards, ongoing staff training, and continuous monitoring of infection risks.
Environmental Controls
• Immediate segregation of clean and dirty storage areas. All inappropriate storage practices (e.g., catheter boxes beside toilets, laundry skips in communal bathrooms) have been discontinued.
• A deep-cleaning schedule has been initiated on our new cleaning schedule on Epicare, with maintenance schedule now in place of damaged or uncleanable surfaces, furniture, and fittings including torn fabric seats and peeling cabinet coverings.
• Procurement of individual resident slings, clearly labelled for single-user use, with strict protocols for storage and cleaning.
Staff Training and Awareness
• All staff are receiving refresher training on infection prevention and control, including correct storage practices, cleaning procedures, and use of resident-specific equipment by training company Date to be confirmed
• Spot-check audits and unannounced IPC walkarounds will be introduced to ensure sustained compliance.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
To address the non-compliance identified under Regulation 29, the following actions are being taken:

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Preadmission Assessments

• All preadmission assessments are now conducted exclusively by the management team. 30/06/25

• A review meeting is held within the nursing home prior to each resident's admission to ensure a full evaluation of needs and suitability of placement.

Care Plan Updates and Reviews

• All residents' care plans have been updated to reflect their current needs, including nutritional requirements, wound management, infection control, and other care domains. 30/08/25

• Formal review dates are now set at three-month intervals for all care plans, with earlier reviews conducted if a resident's needs change. 30/08/25

• Nutritional care plans are updated to include Malnutrition Universal Screening Tool (MUST) scores and recommendations from dietitians to ensure the most current guidance is followed. 30/08/25

Training and Staff Guidance

• All nursing and nursing management staff have received targeted training on accurate, timely, and person-centred care planning. 07/08/25

• This training emphasised the importance of removing outdated or historical data from care plans to avoid confusion in care delivery.

• Specific guidance has been issued regarding the development of care plans for residents with a history of multi-drug resistant organisms (MDROs), ensuring infection prevention and control practices are integrated.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

To achieve full compliance with Regulation 6, the following actions have been taken and are ongoing:

GP Admission and Review Practices

• A meeting with the local GPs has been scheduled for 27/09/25 to agree a formal structure for regular in-person visits and reviews.

• Following this meeting, a protocol will be finalised.

Ongoing Medical Reviews

• The proposed structure will include scheduled in-person reviews of residents' health conditions at agreed intervals, including routine medication reviews, rather than relying only on changes or deterioration in health.

• Out-of-hours services will remain in place for urgent or unplanned care, but the emphasis will shift towards proactive, planned medical oversight.

Communication and Oversight

• Clear communication systems with GPs are being maintained via phone and email while awaiting the outcome of the September meeting.
• Once implemented, outcomes of GP reviews will be documented and directly linked into residents' care plans to ensure recommendations are acted upon promptly.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To achieve full compliance with Regulation 9, the following actions have been taken and are ongoing:
Personal Care and Choice
• The shower list is now used solely as a planning guide to assist staff with organisation; it does not determine when residents receive personal care.
• Personal care is offered to each resident daily, in line with their individual preferences and choices.
• Residents' wishes regarding personal care (including preferred days/times, frequency, and type of care) are documented clearly in their electronic care plans.
• These preferences are reviewed regularly with residents and updated as required.
• Resident Involvement and Consultation:
• Residents are consulted directly daily regards personal care and through our resident meetings to ensure their voice is central in decision-making.
Staff Training and Accountability:
• Refresher training has been provided to all care staff on person-centred care, dignity, and residents' rights, emphasising choice, flexibility, and respect. 20/11/25
• Supervisory spot checks are carried out by the Person in Charge (PIC) and Clinical Nurse Manager (CNM) to ensure personal care is delivered in line with residents' wishes, with findings documented and reviewed. 01/08/25
Residents' Meetings and Consultation
• Formal residents' meetings have been reinstated and scheduled every two months. 11/09/25
• Two staff members have been assigned responsibility for coordinating and documenting these meetings.
• Feedback and actions from meetings will be recorded and shared with management to ensure residents' voices directly influence the running of the centre.
Activities and Engagement
• Weekend activities remain dedicated to family, friends, and social events, as requested during resident meetings. These practices are monitored and adjusted based on residents' feedback. 11/09/25
• Parties and events are organised in line with residents' wishes, as expressed during resident meetings. This practice will continue to be monitored and adjusted as needed, ensuring that residents' preferences remain central to activity planning.
• A monthly activity schedule is now prepared by the activity coordinator and displayed prominently on the wall in communal areas.
• Activities are outlined for each month in advance, giving residents the opportunity to plan and make informed choices about their participation.

Accessibility of Information

• The activity schedule is available in clear, accessible formats to ensure inclusion of residents living with dementia and cognitive impairment. 01/09/25
• Staff have been reminded to review the schedule with residents individually, where required, to ensure they are supported in making choices.

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
Regulation 14(1)(a)	The registered provider shall ensure that the designated centre has a person in charge.	Not Compliant	Orange	01/05/2025
Regulation 14(1)(b)	The registered provider shall ensure that the designated centre has a person who is able to deputise in the absence of the person in charge.	Not Compliant	Orange	13/06/2025
Regulation 14(9)	In the absence of the person in charge, the person who will deputise for the person in charge shall be a registered nurse working in the designated centre with not less than 3 years' experience of nursing older persons within the previous 6 years.	Not Compliant	Orange	01/05/2025
Regulation 15(1)	The registered provider shall ensure that the	Substantially Compliant	Yellow	13/06/2025

	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.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	13/06/2025
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	03/10/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/08/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Not Compliant	Orange	13/06/2025

	the statement of purpose.			
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.	Not Compliant	Orange	13/06/2025
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Not Compliant	Orange	13/06/2025
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	15/06/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Orange	13/10/2025

Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	30/07/2025
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.	Not Compliant	Orange	30/07/2025
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or	Not Compliant	Orange	30/07/2025

	risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/10/2025
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	16/09/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/06/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Not Compliant	Orange	30/08/2025

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Substantially Compliant	Yellow	27/09/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	01/09/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	01/09/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted	Not Compliant	Orange	11/09/2025

	about and participate in the organisation of the designated centre concerned.			