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:	Dalkey Community Unit for Older Persons
Name of provider:	Health Service Executive
Address of centre:	Kilbegnet Close, Dalkey, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	13 March 2025
Centre ID:	OSV-0000510
Fieldwork ID:	MON-0045851

About the designated centre

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

The centre is based in South Dublin and is run by the Health Service Executive. The centre is close to bus routes no 29 and no 8 and to the dart service. It was purpose built in 2000 and provides 34 registered beds. There is also a day care service run on the same premises. The staff team includes nurses and healthcare assistants at all times, and access to a range of allied professionals such as physiotherapy and occupational therapy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	33

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 13 March 2025	08:40hrs to 17:45hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

The overall feedback from residents was that they were happy and content living in Dalkey Community Unit for Older Persons. The residents spoken with were complimentary of the staff, with residents describing staff as "very kind". While residents praised staff, there was some mixed feedback from residents and their family members about the care received. Some residents spoken with said they were very happy with the care being provided. One resident described staff as being "good" and that they responded to their call-bell in "good enough time". However, some residents spoke of delays to care being provided when required. The inspector also observed some delays in staff responding to call-bells. Following on from the previous report, some residents also expressed concern about the number of agency staff used in the centre and said they did not know their care needs well. In addition, some residents expressed their concern over not being able to access physiotherapy as the post had been vacant for several months.

Following an opening meeting, the person in charge accompanied the inspector on a tour of the centre. During the day, the inspector spoke with several residents and visitors to gain insight into the residents' lived experience in the centre. The inspector also spent time observing interactions between staff and residents and reviewing a range of documentation.

The centre is a two-storey building located in the heart of Dalkey, close to local shops, and with scenic views of the castle. Residents are accommodated on the first floor and divided into two units, referred to as Castle View and Hill View. The hill view unit consisted of 12 single occupancy bedrooms, six of which have en-suite facilities and six which have access to shared communal bathrooms, three double rooms, which all have en-suite facilities and two triple bedrooms, with access to shared communal bathrooms. Following on from the previous inspections, the registered provider had completed the reconfiguration of the Castle View unit, and all twin bedrooms were now single occupancy bedrooms. On the day of inspection, there were 10 single occupancy bedrooms on castle view unit. This had reduced the number of registered beds, in line with the registered providers condition 1 and condition 3 of registration. The number of the centre's registered beds has been reduced from 36 to 34 registered beds.

Residents' bedrooms were personalised with photographs, pictures, art and items of significance belonging to the residents. As per the provider's compliance plan, additional wardrobe storage had been built into an annex space outside of one of the triple bedrooms. Glass panels that were on residents' bedroom doors also now had a blind which could be pulled closed to allow residents to have privacy when in their bedrooms. Within the Hill View unit, the layout of one of the bays in the two triple bedrooms did not afford residents enough sufficient space to conduct their activities in private and to have ample seating.

Internally, the centre's design and layout supported residents in moving throughout the centre, with wide corridors, sufficient handrails, furniture and comfortable seating in the various rest areas and communal areas. On the first floor, communal space consisted of a large bright dining room, smoking room, sitting room and an oratory. Residents on the first floor also had access to an outdoor patio area. This was well-maintained and had a new smoking area, which residents were using. However, not all appropriate fire equipment, such as a metal ash tray and emergency call-bell were available for residents to use if needing support. The ground floor consisted of a day service, the laundry, administrative offices, storage and staff facilities.

The inspector observed that the registered provider had made changes to the footprint of the centre since the last inspection. A toilet and a sink had been removed from a communal toilet on the first floor. The room was observed to have hoists stored in it on the day of inspection.

Throughout the day of inspection, residents were neatly dressed and observed to be up and about in the various areas of the centre. Activities took place in the dining room and the sitting room. In the morning, residents attended live music and could be seen to enjoy this as they were singing along and toe-tapping. In the afternoon, residents did some exercise in the sitting room. Residents spoken with said they enjoyed the activities provided.

Many of the residents were observed to eat in the dining room for their meals. Lunchtime was observed to be a sociable and relaxed experience. Dining room tables were set and a menu was available for residents to choose from, with two options available to them. Overall, residents spoken with said the food was good, there were lots of options for them to choose from and the food options changed everyday. However, for some residents with modified diets, some further assurances were required to ensure that their dietary needs were met. This is detailed under Regulation 18: Food and nutrition.

Residents were observed to be receiving visitors with no restrictions throughout the day and it was evident that visitors were welcome. The inspector spoke with three visitors in detail. They were were generally complimentary of the staff in the centre, however they also gave feedback that there was a high number of agency staff in the centre, who they felt, did not know the residents' care needs well. This correlated residents' views that there were delays to care being provided and felt at times there was a shortage of staff. Those spoken with also expressed their view that the governance and management oversight within the centre needed to be strengthened, and more robust. They also felt that there should be more opportunities for residents to engage with the person in charge and be consulted in the running of the designated centre. The visitors also gave feedback on their concerns that residents were not able to access physiotherapy, as this post had been vacant for six months. The inspector was informed that this post was advertised, however, the provider was unsuccessful in filling the position. Similar concerns were also raised by family members at a residents' meeting in February 2025 and October 2024 in relation to high numbers of agency staff in the centre, staff being unfamiliar with the residents' needs, residents being unable to access

physiotherapy as this post was vacant and for strengthened management oversight in the centre.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

While governance and management systems were in place to oversee the quality of care delivered to residents, and some improvements were evident since the inspection in August 2024, further actions were required to ensure the service provided was safe, appropriate, consistent and effectively monitored, as discussed within this report.

This was an unannounced inspection to assess the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended) and to review the registered provider's compliance plan arising from the previous inspection. It was carried out over one day by one inspector. The inspection also informed the provider's application to renew registration. The inspector also followed up on solicited information that had been submitted to the Chief Inspector.

The Health Service Executive (HSE) is the registered provider for Dalkey Community Unit for Older Persons. The senior management team structure was clear, with a management team comprising the head of social care in the area, general manager for older persons, person in charge and a unit manager. There was clear lines of accountability and responsibility. The person in charge had worked four days a week in the centre, which had currently increased to five days a week. They reported to the general manager for older persons and was supported in their management role by two clinical nurse managers (CNMs). The person in charge was also responsible for the oversight of a team of nurses and healthcare staff, activity staff, catering, household and portering staff.

The registered provider had audit and monitoring systems in place to oversee the service. However, the audit system was not fully effective and sufficiently robust as it had failed to identify key areas for improvement in areas such as, governance and management and assessment and care plans. The person in charge had introduced a new audit system for assessment and care plans and these were being completed. However, the audits for the Castle View unit had a score of 100% and did not identify the areas of non-compliance found on this inspection. Care plan audits completed in Hill View had identified areas for improvements. A care plan audit that was completed in January 2025 for Hill View had identified areas for improvement, however, these actions were still not completed on the day of inspection. The

registered provider had also committed to completing weekly call-bell audits using the call-bell system in place to ensure robust oversight. However, the inspector was informed, by the person in charge, that this was currently not being completed due to a reported fault with the system. Records available evidenced that only two call-bell audits had been completed for 2025, both in February. In addition, there was no annual review completed for 2024 and no plan in place for when this would be completed. There were also gaps in daily managers audits to ensure oversight in the centre. For example, records reviewed had no entries since 17 February 2025, so there was no record of this audit being completed.

There was documentary evidence of communication between the person in charge and the head of social care. Records of monthly senior management meetings were reviewed since the last inspection in August 2024. These had been attended by the person in charge, head of social care, general manager and CNMs. Regular staff meetings were also taking place, and these were attended by the CNM, nurses and healthcare staff. Meetings with residents were taking place every four months and attended by residents, some family members and CNMs. Residents had requested more frequent meetings to ensure they get feedback from questions and issues raised at the meetings sooner. In a residents' meeting in October 2024 they were informed the meetings would take place every two month; however, the next residents' meeting took place four months later, in February 2025.

The registered provider had progressed with the compliance plan, and some improvements were identified in protection, residents' rights, managing behaviour that is challenging, records, premises and temporary absences or discharge of residents. While some actions had been completed, there were actions detailed in the compliance plan following the last inspection, which had not yet been taken to address areas of non-compliance.

Changes had been made to the staff arrangements within the centre. During the day, the number of nurses on the Castle View unit had reduced from two to one and the number of healthcare assistants had increased from two to three. In the Hill View unit, the number of healthcare assistants had increased by one in the morning, to meet the residents' needs. There was also an additional healthcare assistant to provide one-to-one care to a resident. However, there continued to be a high use of agency staff in the centre and feedback from some residents and family members was that they were not aware of their care needs. Although the skill-mix of staff had been changed to try meet the care needs of residents, some delays were observed to care being provided to residents and had impacted the quality of care provided to residents. For example, the inspector observed two occasions where residents had to wait over seven minutes for staff to respond to the call-bell to attend to their care needs.

Since the last inspection, the person in charge had worked hard to ensure that records were available in the centre, such as Garda vetting disclosures and the details required under Schedule 2 of the regulations. They implemented a new system of maintaining these records within the centre so they are accessible. All staff files and Garda vetting disclosures were available for review by the inspector.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to renew the designated centre's registration in accordance with the requirements in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015. At the time of inspection, this application was being reviewed.

Judgment: Compliant

Regulation 21: Records

The inspector reviewed a sample of four staff files. The registered provider had ensured that the records set out in Schedule 2 were kept in the designated centre and available for review on inspection by the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

While the registered provider had assurance systems in place, these were not fully robust to assure the quality and safety of the service. For example:

- The registered provider had removed the sink and toilet from a communal toilet without informing the Chief Inspector, meaning the centre was not operating in line with condition 1 of their certificate of registration.
- The management oversight of residents' individual care needs, assessments and care plans was not fully effective and required further oversight. Although care plan audits were taking place, some were not identifying areas for quality improvement. Where the audits were identifying areas for improvement, the oversight system to ensure actions were completed was not effective.
- The registered provider had committed to completing weekly call-bell audits in the compliance plan; however, only two call-bell audits had been completed since the last inspection, in February 2025.
- The systems in place to ensure residents dietary requirements were met was not fully effective. For example, some care plans had differing information about residents' modified dietary requirements when compared to their assessed needs. In addition, the list provided to catering staff also had some

differing information for residents dietary requirements. This is further detailed under Regulation 18: Food and nutrition.
- Some actions detailed in the compliance plan following the last inspection had not yet been taken to address areas of non-compliance. For example, some of the fire precautions were still not fully completed. This is detailed under Regulation 28: Fire precautions.

On the day of inspection, the annual review of the quality and safety of care delivered to the residents for 2024 had not been completed, with no plan in place to address this.

A review was also required to ensure the registered provider had allocated sufficient staffing resources for effective delivery of care and was meeting the needs of residents. For example, the inspector observed two occasions where residents had to wait over seven minutes for their call-bells to be responded to.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1 of the regulations.

Judgment: Compliant

Quality and safety

While efforts were made by the nursing and care staff to provide a good standard of care to the residents, the inspector found that further improvements were required. As described above, the current management systems in place to ensure the service was safe and appropriate impacted on the quality of care being delivered to residents. The impact of this is described under the relevant regulations below.

Residents' social and health care needs were assessed using validated tools. Comprehensive assessments were completed on or before the residents' admissions to the centre. The centre was using a paper-based system for care planning. The inspector was informed that an electronic system would be replacing this system, in the coming months. Some gaps were observed in relation to the accuracy of the information within care plans and some assessments did not correlate with care planning information. As a result, the care plans did not effectively guide appropriate care to some residents.

An up-to-date safeguarding policy was in place to guide staff in the event of a concern of abuse arising. All staff had completed safeguarding training. All possible safeguarding concerns had been identified and reported. However, a resident with a safeguarding concern did not have a safeguarding plan in place to ensure they were protected from abuse. The provider was a pension agent for 23 residents. A review had taken place of the systems used to manage residents' money. Records shown to the inspector confirmed residents' money was managed through a separate client account. Money was also held locally for residents' daily use and the inspector was assured that the systems in place protected residents' finances.

Residents were generally complimentary regarding food, snacks, and drinks. Food was prepared and cooked onsite. Choice was offered at all mealtimes, and adequate quantities of food and drinks were provided during the day and in the evening. Residents had access to fresh drinking water and other refreshments throughout the day. There was adequate supervision and discreet, respectful assistance at mealtimes. However, improvements were required to ensure that the dietary needs of residents, as prescribed by a healthcare professional, were met and that food and drinks were properly served.

Overall, the premises was in a good state of repair and met the needs of residents. The centre was found to be warm and bright with a variety of communal areas observed in use by residents on the day of inspection. However, the registered provider had also failed to engage with the Chief Inspector in respect of proposed changes to the premises and had removed a toilet and a sink from a communal toilet in the centre, as previously discussed.

While the centre was generally clean on the day of inspection, a number of areas for improvement were identified to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018), and this will be discussed under Regulation 27.

Some improvements were observed in relation to fire precautions since the last inspection. Fire drills were now taking place monthly and a new recording system had been implemented to capture these taking place. While efforts had been made to implement new fire safety systems, further action was required, which is detailed under Regulation 28: Fire precautions.

Regulation 17: Premises

Some improvement was required by the provider to ensure that the premises were appropriate to the number and needs of the residents of the designated centre and in accordance with the statement of purpose prepared under Regulation 3. The

registered provider had removed a toilet and a sink from a communal toilet in the centre and converted this area into storage.

While additional storage space had been created for the triple bedrooms in the Hill View unit, the layout of one of the bays in the two triple bedrooms, did not afford residents enough sufficient space to conduct their activities in private and to have ample seating. This was also highlighted to the provider in the last inspection.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

While some good practice was observed to the mealtime experience, some improvements were required to ensure the dietary needs of residents, as prescribed by a healthcare professional, were met and that food and drinks were properly served. For example:

- A resident who was a diabetic had a nutrition care plan in place, however, it did not detail that the resident was a diabetic and how to meet the resident's dietary needs. In addition, the resident had recently been assessed and their modified dietary needs had changed. However, their care plan had not been updated to reflect their changing needs.
- A resident who required a modified diet had a care plan in place. Changes had been made to the type of modified diet which the resident was to receive in their care plan, however, this was not based on an assessment of their needs. In addition, the information provided to staff when serving the resident their meal was different to the information in their care plan.
- A resident with weight concerns had been assessed by a dietitian, however their nutrition care plan in place did not address their weight concerns and did not include the dietitian recommendations.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

The person in charge ensured that when the resident was transferred to and from the hospital, all relevant information about the resident was provided to the receiving hospital. Similarly, when the resident returned to the centre, the person in charge took reasonable steps to ensure all relevant information about the resident was obtained from the hospital.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018). However, some storage practices posing a risk of cross-contamination required review. For example:

- Some clinical equipment was stored with non-clinical equipment. This posed a risk of potential cross-infection.
- Some boxes stored on the floor in the linen room. This would impact the ability to ensure effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While the registered provider had increased the number and frequency of fire drills taking place to ensure an adequate means of fire safety management, records reviewed had gaps in the information being recorded. This was also not in line with the centre's own policy. For example, the number of staff who took part in the fire drill was not always recorded. Therefore it was not possible to ascertain if residents could be evacuated in a timely manner to a place of relative safety.

A new smoking shelter had been built for residents to use. However, not all appropriate fire equipment, such as a metal ash tray and emergency call-bell was available for residents to use if needing support.

Following on from the last inspection, the registered provider had replaced some maps on the walls showing the layout of the centre which correctly identified the compartments in the centre. However, some of the maps had not been replaced and did not contain this information to ensure that the arrangements for containing fires would be adequate.

A review was also required to ensure that the registered provider had adequate means of escape. An example was seen where a trolley was placed in the corridor outside of the laundry room each day for prolonged periods of time, this would impact the means of escape in the case of an emergency. This was moved immediately to a temporary location on the day of inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents were not able to access physiotherapy as required. For example, the physiotherapy post has been vacant for six months. A resident who was assessed as requiring regular physiotherapy had not seen a physiotherapist for four months.

From a sample of care plans reviewed, they did not always reflect the specific health, personal or social care needs of the resident, which impacted on the quality and care provided to residents. For example:

- A resident had a mobility care plan in place, however this did not accurately reflect their assessed needs.
- A resident with responsive behaviour (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had a care plan in place. However, it did not detail their assessed needs and supervision requirements to guide staff practice. The care plan also detailed the requirement for an antecedent behaviour consequence chart (ABC) to be completed and all behaviours observed to be recorded. There was an ABC chart in place, however, there were no records of any incident in the previous month. The inspector had been informed by staff and observed frequent instances of responsive behaviours.
- Another resident with responsive behaviours had been risk assessed as requiring one-to-one staff supervision, however, this was not in the resident's care plan and was not in place. There had been two significant incidents and the resident's care plan was recorded as being reviewed. However, no changes were made to the resident's care plan.

Judgment: Not compliant

Regulation 8: Protection

While the management team had responded appropriately to safeguarding incidents, and followed their policy, a resident who had safeguarding concerns did not have a safeguarding care plan in place to ensure they were protected from abuse.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Dalkey Community Unit for Older Persons OSV-0000510

Inspection ID: MON-0045851

Date of inspection: 13/03/2025

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Clinical Governance & Care Planning • All registered nurses are attending nurse care plan training during the month of June to enhance the effectiveness of individualised care plans and assessments and to ensure same are reflective of resident's needs. • A monthly care plan audit is in place to monitor quality improvements and ensure timely implementation of identified actions. • Recommendations from three recent visits by the Community Speech & language Therapist (SLT) have been incorporated into Residents' care plans. 2. Call Bell System & Responsiveness • An upgraded call bell system has been installed, with a protocol established to generate and review weekly call bell audits. • Local Clinical Nurse Manager 2s (CNM2s) and the nurse in charge are responsible for ensuring timely response to call bells. Audit findings are reviewed weekly, and corrective actions taken as necessary. • The Director of Nursing (DON) oversees regular audits of response times and maintains daily oversight of staffing levels and resident dependency. 3. Staffing & Resource Allocation • The DON has authority to allocate additional staff during periods of high activity. • Supernumerary CNM2 staff are redeployed to direct care roles during peak times to support frontline teams. • A daily safety huddle is conducted to identify and address emerging issues in real time, with staff reallocated as needed. • Ongoing issues are escalated to the General Manager (GM) or the Registered Provider Representative (RPR) for resolution. 4. Dysphagia Management and Nutritional Care • 90% of staff have completed the Introduction to the IDDSI Framework via HSELand. • All residents are risk assessed for dysphagia, with referrals made to Primary Care Services as appropriate.	

• The Community SLT continues to provide staff education and training.
• Each resident is screened by the SLT and Dietician where indicated to reduce risk and enhance delivery of safe effective care.
5. Communication & Family Engagement
• Family meetings, delayed due to seasonal illness outbreaks, were held in February and April, with the next meetings scheduled for August and December.
• Local CNMs maintain regular contact with residents and families, escalating concerns to the DON as needed.
6. Fire Safety & Emergency Procedures
• All staff participate in the fire drills and fire safety awareness training, with attendance and drill duration recorded.
• The HSE Fire Officer is available to the Centre as required to escalate any issues or concerns or to seek advice. This has been re-enforced with the PIC and the HSE Fire Officer directly by the RPR
7. Oversight & Continuous Improvement
• The Annual Review of Quality & Safety has been completed, incorporating feedback from family and staff meetings, complaints, and investigations. A copy of this has been submitted to the Inspector.
• Regular governance and oversight meetings with the GM continue, with issues escalated to the RPR as required.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The inner bed space in the triple-bedded room is designated specifically for residents with enhanced mobility. Admission to this bed space is strictly limited to individuals who meet this mobility profile, ensuring their comfort, safety, and ease of access within the space.
• The Centre provides multiple communal and quiet seating areas throughout the premises. Should a resident request a private space for personal or therapeutic activities, this can be facilitated promptly within the Centre, ensuring privacy, dignity, while respecting the wishes of the Residents at all times.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
1. Individualised Nutritional Assessment & Care Planning
• All registered nurses are attending care plan training in June 2025. The training focuses

on ensuring that the needs of each Resident (to include nutritional) are accurately assessed, documented, and regularly reviewed.
• Care plans are updated to reflect current dietary requirements, preferences, and any therapeutic or texture modified diets, in line with the International Dysphagia Diet Standardisation Initiative (IDDSI) framework.
2. Ongoing Monitoring & Quality Assurance
• A monthly care plan audit is in place to ensure that nutritional care plans are:
· Up to date
· Reflective of current clinical and dietary needs.
· Reviewed in consultation with residents and/or their families.
• Audit findings are discussed at the local quality and safety meeting in the Centre.
3. Specialist input & Multidisciplinary Collaboration
• The Community SLT has conducted three visits to the Centre since the last Inspection to further assess Residents and provide bespoke interventions/ recommendations.
• All SLT recommendations have been incorporated into Residents' care plans and communicated to relevant staff.
• Ongoing education and toolbox talks are being delivered by the Community SLT to ensure staff competency in managing dysphagia and texture-modified diets.
4. Implementation of Electronic Care Planning
• Staff training on the Epicare electronic care planning system took place in May. The system will go live in Quarter 3, 2025 and will:
· Enable real-time updates to nutritional care plans
· Provide alerts for overdue reviews.
· Improve interdisciplinary communication and documentation accuracy
· Ensure non-nursing criteria is reflected to fully inform Care needs

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Segregation of Clinical & non-Clinical Equipment
• The Laundry and Store Room have been reconfigured to ensure that only non-clinical equipment is stored in these areas.
• All clinical equipment has been relocated to designated clinical storage areas to eliminate risk of cross-contamination.
2. Improved Storage Practices
• All boxes and supplies are now stored off the floor on appropriate shelving units, in line with best practice for infection prevention and control.
• The linen room has been decluttered, and a clear floor policy is enforced to facilitate effective cleaning and reduce contamination risk.
3. Daily Environmental Monitoring
• The laundry room and store room are checked daily by the CNM and spot checks are carried out by the DON to ensure:
· Floors remain clear.

· Storage practices are correct.
· Any non-compliance is addressed immediately.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Comprehensive Fire Drills
• A Centre-wide fire drill will occur at least quarterly, to ensure that all staff, across all shifts (weekday, weekend, night, and agency staff) participate in regular fire drills.
• Drills are conducted at least quarterly, with scenario based evacuations that reflect different times of the day and resident dependency levels.
• Each drill includes a full or partial evacuation to a place of relative safety, in line with the Centre's fire safety policy and compartmentalisation plan.
2. Enhanced Fire Drill Record-Keeping
• Fire drill records now include:
· Date and time of the drill.
· Staff and residents involved.
· Evacuation time and route used.
· Compartment evacuated.
· Barriers or delays encountered.
· Learning outcomes and corrective actions.
3. Resident Involvement & Evacuation Feasibility
• Residents are included in fire drills where appropriate and safe, particularly those with low mobility needs.
• For residents with high dependency or cognitive impairment, simulated evacuations using evacuation aids where needed/appropriate are conducted to assess feasibility and timing.
• Each resident has a Personal Emergency Evacuation Plan (PEEP), which is reviewed quarterly or following any changes in condition.
4. Staff Training & Competency
• All staff receive mandatory annual fire safety training, including:
· Use of fire extinguishers
· Evacuation procedures
· Compartmentalisation awareness.
• Training is monitored locally by the CNMs with oversight of the DON, and refresher sessions can be scheduled where deemed required.
• New staff must complete Fire Safety training as a matter of priority on commencement of employment.
5. Oversight & Continuous Improvement
• The DON conducts random spot checks during drills to assess staff response and adherence to protocols.
• Outcomes from drills are discussed at quality and safety meetings, and any identified risks are escalated to the GM and/or RPR.
• A dedicated Fire marshall is nominated to carry out weekly checks and maintain a log

of same
• All fire evacuation points are checked to ensure egress points are unincumbered
• All issues identified are escalated, as required, to the PIC and if necessary to the PPIM/RPR.

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:
1. Comprehensive Assessment & Care Planning
• All residents have a full assessment of needs using validated assessment tools (E.g. MUST, Waterlow, MMSE, and Barthel Index)
• Each resident now has an individualised care plan developed in consultation with the resident, and where appropriate, their family or representative.
• Care plans are reviewed at least every four months, or sooner if there is a change in the resident's condition, in line with regulation 5(4).
2. Care Plan Quality Assurance
• A monthly care plan audit is conducted by the CNM team, with oversight from the DON. This audit includes:
· Accuracy and completeness of assessments.
· Evidence of resident and family involvement.
· Timeliness of reviews and updates.
· Alignment with residents' current need and preferences.
• Audit outcomes are discussed at the quality and safety meetings and action plans are developed for any deficits identified.
3. Addressing Specific Care Needs (E.g. One-to One Supervision)
• Residents identified as requiring one-to-one supervision have been reassessed, and appropriate schedules are now in place
• Staffing rosters are regularly reviewed to ensure adequate supervision is maintained, and this monitored daily by the CNM or nurse in charge.
4. Incident Recording & Learning
• All incidents are recorded and managed in accordance with the HSE's Incident Management Framework.
• Incidents are reviewed locally and where appropriate and in line with the IMF escalated to the Divisional Quality and Safety meeting for further review, investigation and appropriate action.
• A member of the Quality, Safety and Service Improvement (QSSI) team is assigned to the Centre and reviews all NIMS forms submitted. The QSSI team will liaise with the service as needed in relation to incidents and follow-up.
• The DON reviews all incident reports to ensure appropriate follow-up and learning.
• All incidents/trends are identified and reviewed at the Divisional Quality & Safety meeting to inform/improve practice and circulate appropriate learning notices and service improvements initiatives.

5. Access to Allied Health Services
• Recruitment for a Senior Physiotherapist is underway with interviews due to take place in mid-June. This follows two failed competitions to recruit.
• Once the new Physiotherapist commences all residents will be rescreened for physiotherapy needs, and those requiring intervention have care plans updated accordingly.
6. Staff Training & System Implementation
• All registered nurses are attending care planning training in June to enhance documentation and clinical reasoning skills.
• The Epicare electronic care plan system will go live in quarter 3, 2025, enabling:
· Real-time updates
· Alerts for overdue reviews.
· Improved interdisciplinary communication.
7. Oversight & Governance
• The DON provides daily oversight of care planning and staffing adequacy.
• Feedback from Residents and staff is actively sought and used to inform care planning and service improvements.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. Safeguarding Policy & "No Tolerance" Culture
• The Centre has adopted a no tolerance policy towards abuse, which is clearly communicated to all staff, residents, and families.
• A Safeguarding Vulnerable Persons Policy is available and is in line with national guidance and HIQA standards. Policies can be made available to residents and families on request.
• A Safeguarding Statement is prominently displayed in the Centre.
• A Safeguarding Lead is in place to ensure residents have a dedicated point of contact to discuss/engage on any Safeguarding concerns/observations that they/Families might have.
2. Staff Training & Awareness
• All staff complete mandatory safeguarding training every three years, the training includes:
· Recognising signs of abuse (physical, emotional, financial, institutional, neglect)
· Reporting procedures
· Resident rights and dignity.
• Staff can access training as required through the HSELand online training system.
3. Resident Risk Assessment & Monitoring
• Any Resident with suspected or confirmed potential safeguarding concerns have a safeguarding care plan in place. Reports are made to the relevant stakeholders.
• Residents with identified vulnerabilities have enhanced supervision protocols and are monitored through daily safety huddles.
• One-to-one supervision is provided where clinically indicated, and staffing rosters

and/or levels are adjusted accordingly.
• All such requirements are escalated to the PPIM and RPR.
4. Incident Reporting & Learning
• All incidents are recorded through the HSE Incident Management Framework.
• Incidents are reviewed and brought to the attention of the quality and safety meeting for oversight and learning.
• A member of the QSSI team is assigned to the centre and reviews all NIMS forms submitted. The QSSI team will liaise with the service as needed in relation to incidents and follow-up.
• Any identified trends are reported to the GM and/or the RPR.
• Unit data is monitored and discussed at the Divisional Quality & Safety Committee.
5. Resident Access to Advocacy & Support
• Residents are informed of their right to independent advocacy, and contact details for advocacy services are readily available in the centre.
• The DON is the appointed Designated Officer to act as a point of contact for Residents, families and staff.
6. Oversight & Governance
• The DON provides daily oversight or safeguarding practices and staffing adequacy, supported by their team of managers.
• Safeguarding is a standing item on the QSEC committee in Older Persons, which is fed into by the Centre.
• The HSE' Safeguarding Lead is an integral part of the Divisional Quality & Safety Committee at which Safeguarding updates are provided by Centre.
• All ongoing/outstanding Safeguarding Plans are discussed as part of this presentation
• The HSE's Safeguarding Lead will escalate any significant concern directly to the RPR.

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 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	30/06/2025
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	30/06/2025
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate	Not Compliant	Orange	31/05/2025

	quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/09/2025
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	30/06/2025
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that	Not Compliant	Orange	25/04/2025

	such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	25/04/2025
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	25/04/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/05/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all	Substantially Compliant	Yellow	31/05/2025

	fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/05/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/05/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/06/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where	Not Compliant	Orange	30/06/2025

	necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	31/05/2025