Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Older People.

# Issued by the Chief Inspector

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| Name of designated centre: | Sacred Heart Hospital |
| Name of provider: | Health Service Executive |
| Address of centre: | Old Dublin Road, Carlow, Carlow |
| Type of inspection: | Unannounced |
| Date of inspection: | 14 August 2025 |
| Centre ID: | OSV-0000549 |
| Fieldwork ID: | MON-0047763 |

## About the designated centre

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

Sacred Heart Hospital is a 63-bed facility located within walking distance of Carlow town centre. Residents' accommodation is arranged in three interconnecting units. The units are Sacred Heart unit has 20 beds, St Clare's unit has 21 beds, and St James' unit has 22 beds. The centre provides care for male and female residents over 18 years of age with continuing care, dementia, respite, palliative care and rehabilitation needs. The centre is registered to provide 44 long-term and 14 rehabilitation beds, including two respite bed for dementia care, two community assessment beds and three short-stay beds. Residents' accommodation is arranged at ground floor level in 14 multiple occupancy bedrooms with four residents in each, one twin bedroom and five single bedrooms. There is a combined communal sitting and dining room in each unit. The provider employs nurses and care staff to provide care for residents on a 24-hour basis. The provider also employs GP, allied health professionals, catering, household, administration and maintenance staff.

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

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| Number of residents on the date of inspection: | 55 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

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

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

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

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

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

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

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Thursday 14 August 2025 | 08:00hrs to 16:40hrs | Niamh Moore | Lead |
| Thursday 14 August 2025 | 08:00hrs to 16:40hrs | Aoife Byrne | Support |

## What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day by two inspectors. Based on the observations of the inspectors and discussions with residents, Sacred Heart Hospital was a nice place to live. The inspectors met with approximately 11 residents and spoke to them in detail, to gain an insight into their experience of living in the centre and their quality of life. Residents told inspectors that they were happy and that they were cared for by excellent, kind staff who always respected their opinions. One resident stated that moving into the designated centre was the best thing that ever happened to them.

Inspectors arrived to the centre at 07:40am and following a brief discussion with management, completed a walk around of the premises. The designated centre is registered for 63 residents with 55 residents living in the centre on the day of the inspection. The centre is registered to provide support to residents for long-term, rehabilitation, respite care, community assessment and short-stay. The premises is located on a ground floor level with three self-contained units referred to as St Clare's, St James' and Sacred Heart. Following this walk around, inspectors met with the person in charge to complete an introductory meeting.

Residents' accommodation was in 14 four-bedded rooms, one twin bedroom and five single bedrooms with en-suite facilities. Bedrooms were warm and clean, and inspectors saw that many residents had personalised their bedrooms spaces with their personal belongings. In the morning, the inspectors observed that many bedroom doors were open with a sign outside the door which outlined that residents were receiving personal care, however, this was not seen to be occurring as residents were seen sleeping in their beds. As these bedroom doors were open, it meant the residents who were still in bed were visible to people walking by. Most residents spoken with were happy with their bedroom accommodation, however some of the long-term residents were accommodated in multi-occupancy bedrooms with short-term residents, which meant they were disrupted due to the frequent changes in residents. In addition, inspectors observed some of the vacant beds were unmade which took away from the homely environment for the other occupants of these rooms.

The location, design and layout of the centre was generally suitable for its stated purpose and met residents' individual and collective needs. The centre was observed to be safe and secure, with appropriate lighting, heating and ventilation. There was ample communal space for residents to spend time together, and also some smaller areas to receive visitors. Residents also had access to enclosed courtyards with seating available for residents' use, however inspectors noted that some areas within the courtyard were uneven and therefore potentially a hazard for someone with mobility concerns. While the premises was overall clean, there was wear and tear to many areas of paint work which would not support effective cleaning.

There was information boards available which outlined advocacy and other support services available. There was an activity calendar on display in the centre, and many photographs which showcased the activities held in the centre. This included a recent owl visit the week of the inspection. The activities programme varied which included dog therapy, cinema club, bingo and flower arranging. Activities which occurred on the day of the inspection included a staff member reading from a book to a small group of residents, board games and baking. Inspectors observed meaningful engagements with residents and staff, where staff clearly knew residents well. Residents confirmed that they felt safe within the centre and that staff treated them with courtesy, patience and kindness. However, not all residents' rights were upheld such as access to newspapers and respecting their choices.

Staff spoken with reported that the designated centre was a nice place to work, they demonstrated good knowledge of policies and procedures, training material for example on induction and safeguarding measures. Improvements were required in respect of fire safety precautions to ensure residents' safety was maximised and promoted at all times. This included staff practices, as well as appropriate containment measures and will be further discussed within this report.

Inspectors observed the lunch being served. On the day of the inspection, there was a choice of chicken casserole or corned beef. Inspectors saw there were enough staff on duty to support residents at meal times. Most residents were observed enjoying the company of other residents in the dining rooms, and inspectors also saw that tray service was available for residents who wished to take their meals in their bedrooms. Staff were seen offering support to residents to eat and providing them with their preferred choices for drinks. Staff engagements with residents were observed to be discreet, patient and kind.

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

## Capacity and capability

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People (Amendment) Regulations 2013). On this inspection, the inspectors reviewed information, both solicited and unsolicited, received since the last inspection in September 2024. Overall, the findings of this inspection is that residents received a good standard of care. Some improvements were required in the oversight to ensure the service was provided in line with the regulations.

The registered provider had an additional condition attached to the registration of Sacred Heart Hospital which outlined that the registered provider shall, by 31 October 2024, submit to the Chief Inspector of Social Services the information and documentation set out in Schedule 2 of the Health Act 2007 (Registration of

Designated Centres for Older People) Regulations 2015 as amended in relation to any person who participates or will participate in the management of the designated centre. This condition had not been adhered to, however it is acknowledged that at the time of this inspection the registered provider was progressing this.

This designated centre is operated by the Health Services Executive (HSE). The manager of Older Person's services was the person delegated by the provider with responsibility for senior management oversight of the service. The person in charge was the director of nursing and they worked full time within the designated centre. The person in charge was supported in their role by two assistant directors of nursing, clinical nurse managers grade II, clinical nurse managers grade I, nursing staff, healthcare assistants, activity staff, housekeeping and catering staff. The designated centre was also supported by a medical officer, allied health professionals and administrative staff.

Inspectors found that while records as required by the regulations were available, the systems in place did not ensure all records were stored securely. This is further detailed under Regulation 21: Records.

The registered provider had monitoring systems in place to oversee the service such as committees, meetings, auditing and a risk register. The registered provider had completed an annual review of the quality and safety of care delivered to residents in 2024 in accordance with the National Standards. There was evidence of consultation with residents through surveys dated February and July 2024, and an action plan in place to respond to areas for improvement identified. Notwithstanding some good management systems in place, oversight measures did not consistently result in quality improvements or ensure that the service provided was safe, consistent and effectively monitored, particularly in relation to the environment, including premises and fire precautions. This is further discussed under Regulation 23: Governance and Management.

Arrangements for recording accidents and incidents involving residents in the centre were in place and were notified to the Chief Inspector as required by the regulations.

The centre had a complaints policy and procedure which outlined the process of raising a complaint or a concern. It included a review process should the complainant be dissatisfied with the outcome of the complaints process. Inspectors reviewed the complaints log and found that there was an overall low level of complaints which were seen to be well managed. However, inspectors found that an expression of dissatisfaction with any aspect of the service was not always escalated to the management team, or managed in line with the complaints policy. This is further discussed under Regulation 34: Complaints procedures.

## Regulation 21: Records

Not all resident records were stored securely and safely in line with the regulations. For example:

- A storage cupboard with current residents' files was open and easily accessible in the nurses' station which was observed unattended at times.
- A clinical room with current residents' files was easily accessible and was unattended.
- Resident's records were stored outside bedrooms on one unit.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Action was required by the registered provider to ensure effective governance and management. For example:

- While there were audits occurring, recent audits on the premises and infection control had findings which were not in line with inspectors findings. For example, the premises audit identified 99.64% compliance in June 2025 and 98.45% compliance in February 2025, which did not reflect on the wear and tear and poor storage seen on the day of the inspection.
- An audit on fire doors completed in February 2024 identified areas for improvement and the registered provider had identified the requirement for a fire safety risk assessment, however there was no action plan in place with a person responsible and a timeframe for completion. This is further discussed under Regulation 28: Fire Precautions.
- The oversight systems in place did not identify the impact of having long term residents and short stay residents sharing the multi-occupancy rooms.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

A record of accidents and incidents involving residents and staff in the centre was maintained. Following a sample review of these, inspectors were assured that notifications and quarterly reports were submitted to the Office of the Chief Inspector within the specified time-frames required by the regulations.

Judgment: Compliant

## Regulation 34: Complaints procedure

Inspectors were not assured that when residents voiced dissatisfaction with parts of the service, that this information was escalated to the complaints officer to ensure that appropriate action was taken. For example, during the inspection, the inspectors were told of three complaints that residents had made to the staff that were not recorded and managed in line with the centre's complaints policy.

While evidence of the complaints officer training was available, the review officer had not received suitable training to deal with complaints in accordance with the regulations.

Judgment: Substantially compliant

## Quality and safety

Overall inspectors found that the registered provider was aiming to provide a good standard of care to the residents within Sacred Heart Hospital. Residents spoke positively about the kindness, care and friendliness of the management and staff. However, improvements were required in some areas for the quality and safety of the service, including that of care planning, residents' rights, the premises, fire precautions and medicines.

Inspectors reviewed a selection of resident documentation such as assessments and care plans. Care plans were generally individualised, completed as per regulatory time frames and many clearly reflected the health and social needs of the residents. For example, there were good care plans in place to guide staff on personal care, mobility and meaningful activities. However, inspectors found some examples where care plans were not person-centred and had not been updated to reflect current care practices. This is further discussed under Regulation 5: Individual assessment and care plan.

Residents were provided with access to appropriate medical care. Residents were reviewed by their General Practitioners (GP), as required or requested. Referral systems were in place to ensure residents had access to allied health and social care professionals for additional professional expertise.

The provider had measures in place to safeguard residents from abuse. There was a safeguarding policy in place to provide support and guidance to staff in recognising and responding to allegations of abuse. All staff had appropriate vetting completed by An Gardai Siochana prior to commencing employment in the centre. The provider acted as a pension agent for 11 residents and all pensions were paid into a separate resident bank account. Records showed that a ledger was maintained detailing each resident's payments and surplus amounts was available to review. Records viewed by inspectors demonstrated that there was a system in place to transfer the funds in the resident's account, to pay for resident care provision. However, inspectors

observed that residents didn't have a choice or instant access to their surplus finances, this is further discussed under Regulation 9: Residents' rights.

Residents had access to advocacy services and information regarding their rights. Residents were supported to engage in activities that aligned with their interests and capabilities. There was a number of information notice boards strategically placed along corridors. However, inspectors observed where residents were not facilitated to communicate freely and in particular have access to newspapers. This is further discussed under Regulation 9: Residents' rights.

The centre was clean and the premises was suitable for the needs of the residents living there. There was a programme of maintenance works in place, with external painting occurring during this inspection, however, areas of wear and tear to internal paintwork, flooring and uneven pavement and damaged furniture and planters in courtyards impacted on effective cleaning and a homely environment. This is further discussed under Regulation 17: Premises.

Arrangements were in place to ensure that the transfer of residents from the designated centre to hospital, or other health care services, occurred in line with the requirements of the regulations. However, it was not evident that arrangements to ensure information pertinent to the care of residents were communicated to the receiving health care facility on all occasions. This is discussed further under Regulation 25: Temporary absence or discharge of residents.

The risk management policy was reviewed in February 2025 and outlined the systems in place for responding to risks. There was an emergency plan to outline the measures to take in the event of an incident such as a fire, power outages, flooding and infection control outbreaks.

The registered provider had some good fire safety processes in place. For example, there was a fire safety management policy, fire safety equipment was provided and residents each had personal emergency evacuation plans (PEEP). However, some fire doors were seen to be in a poor state of repair and fire safety training was not up-to-date for all staff. This and further gaps in compliance are discussed under Regulation 28: Fire Precautions.

Inspectors found that overall medicines and pharmaceutical services were in line with the regulations however, on one occasion the practice of medicine storage was unsafe and required review. This is further discussed under Regulation 29: Medicines and pharmaceutical services.

## Regulation 17: Premises

The premises did not fully meet the requirements of Schedule 6 of the regulations. For example:

- Some parts of the interior and exterior of the centre were not well maintained, which impacted a homely environment. This particularly related to:
    - scuffed and chipped paintwork to doors, door frames and skirting boards
    - flooring in some areas was stained
    - some of the external windows were visibly unclean
    - some areas of the pavement in internal courtyards were seen to be un-even, posing a potential trip hazard to residents.
- Inappropriate storage was seen in areas such as communal rooms. For example, wheelchairs and surplus items such as chairs were stored in these areas.
- While there was a door bell in the designated smoking areas, this was not connected to the call bell system. This posed a risk that if a staff member was not present in the corridor or at the nurses' station, the bell would not be heard, preventing a timely response. The inspectors pressed this door bell on two occasions on the day of the inspection and staff did not respond.

Judgment: Substantially compliant

## Regulation 20: Information for residents

The inspectors reviewed the current resident's guide available in the centre and found that it reflected the information required by the regulations.

Judgment: Compliant

## Regulation 25: Temporary absence or discharge of residents

Improvement was required to ensure a record was kept of all relevant information provided about the resident who is temporarily absent from Sacred Heart Hospital to the receiving designated centre, hospital or place. A copy of the transfer letter was not available for a sample of five residents records reviewed.

Judgment: Substantially compliant

## Regulation 26: Risk management

The risk management policy included all the required information in line with the regulations. For example, it detailed the measures and actions in place to control the six specified risks.

Judgment: Compliant

## Regulation 28: Fire precautions

The registered provider did not provide adequate means of escape including emergency lighting for example:

- the directional signage in two areas did not lead to exit points. This created a risk that in the event of a fire, it would direct persons to areas which were not exit points.

The registered provider did not make adequate arrangements for detecting and containing fires. For example:

- There were a number of fire doors that had excessive gaps observed, and some doors which did not close fully. This created a pathway for the potential spread of fire and smoke to the escape route.
- The registered provider could not assure that there was containment in an electrical room off a corridor in the Sacred Heart unit, as there was a gap at the ceiling. In addition, there was no smoke detector in this area.

Improvement was required by the registered provider to make adequate arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout, and escape routes. For example, 21 per cent of staff required refresher training in fire precautions.

The registered provider did not ensure, by means of fire drills at suitable intervals, that persons working in the centre and, in so far as is reasonably practicable, residents are aware of the procedure to be followed in the case of a fire. For example:

- Inspectors reviewed a sample of fire drill records. The drills identified that evacuations were not occurring within the allotted time as set out by the registered provider. This meant that inspectors could not be assured that staff would be able to evacuate residents safely and in reasonable time in the case of fire.
- Some fire drills did not include evacuation details of how the residents were transferred out of the compartment, therefore assurances were not provided that these drills reflected scenarios as outlined in individual residents PEEPs.

Judgment: Not compliant

## Regulation 29: Medicines and pharmaceutical services

Medication management practices required improvements. There was evidence that medicinal products were not stored securely in the centre, for example;

- Inspectors observed an unattended clinical room that stored prescribed medicines was unlocked and keys for the medication trolleys were freely accessible on a table in the clinical room.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

While all residents had care plans in place that were initiated within 48 hours from admission and reviewed at regular intervals, from a review of a sample of residents' records, inspectors found that further action was required in relation to ensuring care plans were based on assessed needs. This was evidenced by the following:

- Residents had a care plan in place for visiting. However these were pre-populated and generic and contained the same information for a sample of five residents reviewed.
- It was identified that all residents had generic safeguarding care plans, including those who did not require them. This has the potential to undermine the purpose of these care plans and divert the focus from the residents who require them.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their GP, and the person in charge confirmed that GPs were visiting the centre, as required.

Residents also had access to a range of allied health care professionals such as physiotherapist, dietitian, speech and language therapy and psychiatry of old age.

Judgment: Compliant

## Regulation 8: Protection

The provider had measures in place to safeguard residents from abuse. Staff were facilitated to attend safeguarding training.

Judgment: Compliant

## Regulation 9: Residents' rights

The registered provider had not ensured that residents were facilitated to communicate freely and in particular have access to newspapers. Residents spoken with reported that in the last two weeks a new system was in place where residents were no longer supplied with communal newspapers. Two residents who have enjoyed reading newspapers on a daily basis since they were young expressed their unhappiness and felt they were "missing this life line".

Inspectors saw two different examples where residents' rights to exercise choice were not fully upheld. For example:

- Inspectors observed that a four-bedded bedroom on the Clare's unit, accommodated three long term care residents and also accommodated one respite resident. Therefore, different residents moved into this bedroom on a weekly or fortnightly basis. A resident spoken with in the room expressed their dissatisfaction with this arrangement and had informed staff regarding this concern. However, management had not recognised this as a complaint.
- The centre acted as a pension agent for 11 residents, however residents did not have instant access to their surplus finances. The system and process in place for residents to access their own money was slow taking up to a week or two for access. One resident was visibly upset when inspectors spoke to them in relation to the length of time to access their finances. The resident had requesting their money on a weekly basis, however this was not occurring at the time. At the end of the inspection management informed inspectors that the resident received their money and that there was now a system in place to access their finances in a timely manner.

Judgment: Substantially compliant

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

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 25: Temporary absence or discharge of residents | Substantially compliant |
| Regulation 26: Risk management | Compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 29: Medicines and pharmaceutical services | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Sacred Heart Hospital OSV-0000549

## Inspection ID: MON-0047763

## Date of inspection: 14/08/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 21: Records | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 21: Records:<br>All records are locked in storage trolleys with key only available to Nursing Staff -Action Completed on the 15/08/2025. All clinical rooms where record trolleys are stored have a push pad lock on door and door closed and locked at all times when not in use, governance provided by ADON and CNMs-Action Completed on the 15/08/2025. Residents' records that where stored outside bedrooms on one unit have been removed and secured securely -Action Completed on the 15/08/2025. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>The ADON with the IPC Link Nurse are reviewing current environmental audit template and are liaising with older person CNS to determine whether an alternative audit tool is available with plan to reaudit environment from an IPC perspective by 30th of December 2025. IPC environmental walk about with ADON, Older Person CNS and IPC Link Nurse to be completed by 30th of October 2025. Internal paint works due to commence the 21st of October 2025 and to be completed by the 18th of November 2025. The male dementia respite service of the availability of one designated dementia bed to the population of Carlow is located in a multioccupancy room with 3 long term residents. There are no single rooms available for this service in the appropriate designated unit, therefore regular communication with long term residents continues and alternative multi-occupancy bedrooms are offered if this is the resident's preference. All concerns voiced by residents or nominated person regarding sharing of room with respite residents are dealt with accordance of the local complaints policy and procedure. In agreement with the Fire Officer, PPIM and DON a weekly schedule to review all fire doors for repair or replacement has commenced from the Technical Services Department from the 16th of | |

September 2025. Estimate date for completion is 06/06/2026. The last Fire Safety Committee meeting held was on the 16th of September 2025 which are quarterly meetings. Fire Officer has provided the centre with an updated Fire Safety Management plan 2025/2026. DON has disseminated this document to all CNMs and technical Service department.

| Regulation 34: Complaints procedure | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The centre has an identified Complaints Officer and Review Complaints Officer. Centre has an up-to-date Policy in place. Last reviewed on 03/06/2025. The contact details and identity of complaints officer is visual throughout the centre. Each unit has a concern /complaints log book in place for documentation when concerns/complaints received. At monthly CNM meetings, all complaints received for the previous month are identified and discussed regarding actions and learnings. DON completes a 6 monthly audit on all complaints received directly to Nurse Management and from all 3 wards, last audit completed on the 06/06/2025, all outcomes, learnings and actions discussed with ADON and CNMS. Next complaint audit due by 30th of December 2025. Monthly resident's forum meeting take place, all meetings' minutes available with actions identified and with date of completion with responsibility of the CNMs with oversight provided by Nurse Management. All staff (90% target) to have completed at least one module on HSELAND on Complaints Handling by 30th December 2025. Review Officer training certificate to be made available to the centre by 30th of December.

| Regulation 17: Premises | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:
Internal paint work to commence the 21st of October 2025 and to be completed by the 18th of November 2025. External window cleaning due for completion by the 30th of October 2025. Doorbell for smoking area for residents daily check by ward staff with documented evidence that bell is in working order. Technical Services liaising with outside agency whether an external call bell can be connected to the internal call bell system, action to be completed by the 30th of October 2025. Internal courtyard improvement works under HSE Estates minor capital works for 2026. All inappropriate storage of wheelchairs and surplus chairs have been removed from communal areas with daily oversight from CNMs and Nurse Management.

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| Regulation 25: Temporary absence or discharge of residents | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
Improvement to ensure a record of all relevant information provided about the resident who is temporarily absent from the centre is photocopied for resident's file. Action required discussed with all CNM. Action completed on the 15th September 2025.

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| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Removal of the directional signage in two areas that did not lead to exit points removed. Action completed on the 6th of October 2025. In agreement with the Fire Officer, PPIM and DON a weekly schedule to review all fire doors for repair or replacement has commenced from the Technical Services Department from the 16th of September 2025. Estimate date for completion is 06/06/2026. The last Fire Safety Committee meeting held was on the 16th of September 2025 which are quarterly meetings. Fire Officer has provided the centre with an updated Fire Safety Management plan 2025/2026. DON has disseminated this document to all CNMs and technical Service department. Electrical room with gap in ceiling and placement of smoke detector to be completed by the 27th of October 2025. On site Fire Drill training scheduled for the 20th of October with two 90minutes training sessions with Fire Safety Trainer and Rescue Specialist. Further dates to be confirmed for 2026.Record of monthly fire drills submitted to Nurse Management. Fire drill audits are completed by Nurse Management quarterly with documented actions if required. Total staff who have completed on line Fire training up to the end of September is 86%. On line fire training continues to be mandatory for all staff.
100% compliance with on line fire training by December 2025.

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| Regulation 29: Medicines and pharmaceutical services | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All clinical rooms have push button lock pads on doors.
Clinical room doors shut and locked at all times when not in use.
Governance provided daily by CNMs, Nurse in charge and Nurse Management.
Medication audits due for completion by the 30th of October person responsible ADON.
Audits completed 6 monthly. Last Drugs and Therapeutic meeting completed on the 23/09/205 and remain quarterly meetings.

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| Regulation 5: Individual assessment and care plan | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Review of all residents visiting care plans currently under review. With completion for evidence of person centre preferences and decision making regarding individual visiting to be completed by the 10TH of November 2025.

Review of all residents Safeguarding care plans currently under review and action required to be applicable to residents who are at risk of abuse and when safeguarding concerns have been reported with actions of safeguarding plans in collaboration with resident and safeguarding team. To be completed by the 10TH of November 2025.

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| Regulation 9: Residents' rights | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Communal newspapers are available daily to all wards. Action completed on the 8th of September 2025. Newspapers are delivered by the Activity team or Nurse Management to ward areas. Standard operating procedure to be put in place for resident's access to monies (pension agent of 11 resident's) by the 30th of December to give clear guidance to the relevant staff who have responsibility regarding access to Resident's own finances. The male dementia respite service of the availability of one designated bed to the population of Carlow is located in a multioccupancy room with 3 long term residents. There are no single rooms available for this service in the appropriate designated unit, therefore regular communication with long term residents continues and alternative multi-occupancy bedrooms are offered if this is the resident's preference. All concerns voiced by residents or nominated person regarding sharing of room with respite residents are dealt with accordance of the local complaints policy and procedure. The resident on the day of inspection has been offered another bedroom but has voiced his preference to remain in current bedroom.

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
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| Regulation 17(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 | 30/12/2026 |
| Regulation 21(6) | Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible. | Substantially Compliant | Yellow | 15/08/2025 |
| 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. | Substantially Compliant | Yellow | 06/06/2026 |
| Regulation 25(1) | When a resident is temporarily absent from a designated | Substantially Compliant | Yellow | 15/09/2025 |

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| | centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place. | | | |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Substantially Compliant | Yellow | 30/03/2026 |
| Regulation 28(1)(c)(i) | The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services. | Substantially Compliant | Yellow | 06/06/2026 |
| Regulation 28(1)(d) | The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and | Substantially Compliant | Yellow | 30/12/2025 |

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| | escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire. | | | |
| 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 | 30/12/2025 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 30/12/2025 |
| 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. | Substantially Compliant | Yellow | 30/10/2025 |
| Regulation 34(6)(a) | The registered provider shall ensure that all | Substantially Compliant | Yellow | 30/12/2025 |

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| | complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan. | | | |
| 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 | 30/12/2025 |
| 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 | 30/11/2025 |
| Regulation 9(3)(c)(ii) | A registered provider shall, in so far as is reasonably practical, ensure that a resident is | Substantially Compliant | Yellow | 08/09/2025 |

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| | facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media. | | | |
| 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. | Substantially Compliant | Yellow | 16/10/2025 |