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:	St Fiacc's House
Name of provider:	St Fiacc's House Company Limited by Guarantee
Address of centre:	Killeshin Road, Graiguecullen, Carlow
Type of inspection:	Unannounced
Date of inspection:	18 March 2026
Centre ID:	OSV-0000554
Fieldwork ID:	MON-0049687

About the designated centre

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

St Fiacc's House was established in 1982. It is owned by the Catholic parish of Graiguecullen/Killeshin and run by a voluntary organisation, St Fiacc's House Ltd. It is a 17-bedded, single-storey centre which provides long-term care for residents who are assessed as having low to medium dependency needs and who require minimal assistance. All residents' rooms are single occupancy. There are six toilets, three assisted showers and an assisted bathroom available for residents. Other accommodation includes two large activity rooms, a dining room, a kitchen and a sunroom. There is also an activity centre with a library, oratory and hairdressing salon. The café, which is located in this area, is open to the public. There is adequate communal space, and the design of the building allows freedom of movement for residents to walk around the centre and grounds. Call bells are provided throughout. There are enclosed and external gardens which are spacious and well maintained. Seating is provided for residents and their visitors. There is ample parking space provided for residents, staff and visitors. According to their statement of purpose, the centre aims to provide a happy, safe and healthy home for older people. It also aims to respect the privacy and dignity of the residents and create a homely, warm and compassionate environment where friends and family feel welcome.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
Wednesday 18 March 2026	09:05hrs to 15:35hrs	Aoife Byrne	Lead

What residents told us and what inspectors observed

Based on the observations of the inspector and discussions with residents and staff, St Fiacc's House was a nice place to live. Residents rights and dignity were supported and promoted by kind and competent staff. The inspector spoke with residents and visitors who were very complimentary in their feedback and expressed satisfaction with staff, the activities programme and food served. Interactions observed were seen to be respectful towards residents and all residents spoken with knew the person in charge and confirmed their accessibility to her.

This was a one day unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). There were 16 residents living in the centre on the day of the inspection. On arrival the inspector spent time walking through the centre, which provided an opportunity to introduce themselves to residents and staff. Some residents were observed to be up and about in the communal areas chatting with each other, while others were having their morning care needs attended to by staff.

St Fiacc's House is a single storey building located in Graigecullen, Co. Carlow and is registered to provide care for 17 residents. The design and layout of the premises met the individual and communal needs of the residents'. The centre was bright and clean with a homely feel. The centre was decorated for St. Patrick's Day. Residents spoke about attending the local parade for St. Patrick's day and how they enjoyed being part of the community.

Residents were very complimentary of the home cooked food and the dining experience in the centre. Residents' enjoyed the homemade meals and stated that there was always a choice of meals, and the quality of food was excellent. There was a choice of two options available for meals daily. The lunchtime meal was observed by the inspector and there was a choice of chicken pie or bacon.

Residents' spoken with said they were very happy with the activities programme in the centre. The weekly activities programme was displayed throughout the centre on notice boards.The morning activity included a crochet class for residents. Those who didn't wish to take part in the class played cards together or listened to music. In the afternoon the majority of residents played bingo and the inspector observed staff and residents having good humoured banter during the activity.

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

Overall, this was a well-resourced centre with some effective governance and management arrangements. The inspector found that the residents were supported and facilitated to have a good quality of life. Further improvements in respect to the oversight of documentation such as policies and procedures and risk management were required to improve compliance.

St Fiacc's House is operated by St Fiacc's House Company Limited by Guarantee which is a limited company with charitable status and is the registered provider. There is a board of directors who are legally required to act in the best interests of the company. The centre is a low-dependency supported care home and was registered on the basis that the residents do not require full-time nursing care in accordance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013-2025.

The person in charge worked full-time in the designated centre and was supported by a team of nursing staff, healthcare assistants, housekeepers, multi-task assistants, catering, maintenance and administrative staff. The registered provider had monitoring systems in place to oversee the service such as meetings, and auditing. Audits were occurring monthly and these included falls, care plans, dining experience and infection prevention and control. The registered provider had completed an annual review of the quality and safety of care delivered to residents in 2025. There was evidence of consultation with residents, and an action plan put in place to respond to areas for improvement identified.

A review of staffing levels showed that the number and skill mix of staff was appropriate to the needs of the residents. Staff were visible in the various areas of the centre and were attentive towards the residents needs.

Inspectors reviewed Schedule 5 policies and procedures and saw that not all of these were in place and had not been updated with recent changes to the regulatory requirements.

The inspector was provided with a hard copy directory of residents to review. The register was available and information relating to any temporary transfers and discharges were up-to-date. However it did not contain all information as required under Schedule 3 of the regulations. This is discussed further under Regulation 19: Directory of residents.

Regulation 15: Staffing

The inspector reviewed rosters which identified that there was a sufficient number of staff employed in the centre. Based on the centre's layout, and the dependency needs of the residents, there was an appropriate number and skill-mix of staff rostered on a daily basis, across all departments, to ensure the residents' needs were met.

Judgment: Compliant

Regulation 19: Directory of residents

An updated directory of residents was available in the centre. However it did not include all of the information as set out in Schedule 3 of the regulations. For example:

- There was no time of death documented for three residents.
- The name and address of the admitting authority was not documented for all residents.

Judgment: Substantially compliant

Regulation 23: Governance and management

Notwithstanding the effective management systems in place. Some systems were not effective in ensuring that documentation was maintained appropriately and kept up to date, such as policies and procedures, information for residents and the directory of residents.This is discussed further under each regulation.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Not all policies and procedures were in place as set out in Schedule 5 of the regulations. For example:

- Provision of information to residents.
- Temporary absence or discharge of residents.

Judgment: Substantially compliant

Quality and safety

Residents were supported to have a good quality of life in St. Fiacc's House which was respectful of their wishes and choices. Residents' health, social care, and spiritual needs were met to a good standard.

Staff were observed to communicate appropriately with residents that had communication difficulties. Residents were afforded time to express themselves and were not rushed. A review of the residents' records showed that when a resident had a communication difficulty, it was appropriately assessed, and all relevant information was recorded in the resident's care plan.

A residents' guide was available in the centre and it contained information on the service and facilities available. It also contained a copy of the complaints procedure and contact details for independent advocacy services. However, it did not contain all information as set out by the regulations. This is discussed under Regulation 20: Information for residents.

Throughout the day it was evident that there was a rights based approach to care in this centre.The inspector saw that residents' bedrooms were nicely decorated with personal belongings, pictures and plants. Residents had the opportunity to meet together and discuss relevant issues in the centre. Residents had access to an independent advocacy service. Residents has access to daily national newspapers, weekly local newspapers, books, televisions, and radio's.

While the registered provider ensured there was a risk management policy in place, it did not set out all risks and actions in place to control the risks. This is discussed further under Regulation 26: Risk Management.

Regulation 10: Communication difficulties

From a review of resident's records it was evident that residents who had communication difficulties were supported to the best of their ability to communicate freely. Each resident who was identified as requiring specialist communication requirements, had these clearly documented in their individual care plan.

Judgment: Compliant

Regulation 13: End of life

End-of-life decision making incorporated residents and their families, where appropriate. The sample of records viewed showed that residents' personal wishes at end of life were recorded, when known.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents of the centre and this was made available to each resident. However, the guide did not include the terms and conditions relating to residence in the centre, and how to access inspection reports.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

There was evidence that when residents were transferred out of the centre to another service that all relevant information accompanied them to the other service. Transfer letters were maintained in the residents' files.

Judgment: Compliant

Regulation 26: Risk management

While there was a risk management policy in place, it did not fully meet the criteria of the regulations. For example, it did not contain the following:

- A process for the implementation of actions and recommendations arising from a serious incident or adverse event.
- A process for the audit, review and learning from events.
- The measures and actions in place to control the risk of abuse, unexplained absence, aggression and violence and self-harm.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Overall, residents' right to privacy and dignity were well respected. Residents were afforded choice in their daily routines. There was evidence that residents were consulted with and participated in the organisation of the centre and this was confirmed by resident's council meeting minutes, satisfaction surveys, and from speaking with residents on the day.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St Fiacc's House OSV-0000554

Inspection ID: MON-0049687

Date of inspection: 18/03/2026

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: Our old residents directory had source of admission grouped under the heading transfers in and out, we have now created a new directory which clearly shows source of admission separately. The 3 deceased residents referred to in our inspection report had passed away in the acute setting, we were not made aware of the time or cause of death but we will endeavor going forward to find out time and cause of death for all our residents who pass away in the acute setting.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Quality improvement plan – Manager of residential services (PIC) and BOD representative have reviewed all schedule 5 policies to ensure that we are line with current regulations.	

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

Full review of all schedule 5 policies has been carried out as mentioned above as part of our quality improvement plan to ensure we are line with all current regulations.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:

Our communication policy now includes the policy and procedure for provision of information to our residents, and we have also included it in our resident's guide.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Quality improvement plan- Following a review of our risk register by Residential Manager, BOD Representative and health and safety committee, our risk register now includes: all risks set out in schedule 5 and includes measures and actions to control:
- Abuse
- Unexplained absence of a resident
- Aggression and violence
- Self-harm

All members of staff have been informed of the amendments to the risk register and all updates in our policies and procedures.
A new template has been created to address the implementation of actions and recommendations arising from audit and review, following a series incident or adverse event. This template includes the process of learning outcomes from these events

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 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	06/05/2026
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include how to access any inspection reports on the centre.	Substantially Compliant	Yellow	12/05/2026
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	12/05/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service	Substantially Compliant	Yellow	13/05/2026

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the implementation of actions and recommendations arising from subparagraph (d).	Substantially Compliant	Yellow	13/05/2026
Regulation 26(1)(f)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the audit, review and learning from events.	Substantially Compliant	Yellow	14/05/2026
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	13/05/2026
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and	Substantially Compliant	Yellow	12/05/2026

	actions in place to control the risks identified.			
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	12/05/2026
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	12/05/2026
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Substantially Compliant	Yellow	12/05/2026
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	12/05/2026
Regulation 04(1)	The registered provider shall	Substantially Compliant	Yellow	13/05/2026

	prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.			