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:	Fairy Hill Nursing Home
Name of provider:	Fairy Hill Nursing Home Limited
Address of centre:	Kennel Hill, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	04 March 2025
Centre ID:	OSV-0005681
Fieldwork ID:	MON-0046542

About the designated centre

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

Fairy Hill Nursing home is a designated centre registered to provide care to 22 residents. The centre is a split-level building situated on the outskirts of Mallow town and close to all local amenities. It is set in well-maintained grounds and has an enclosed courtyard with plants and garden furniture for residents' use. Bedroom accommodation includes a mixture of single and twin bedrooms some with en-suite toilet facilities, others with bathrooms in close proximity. Communal accommodation is provided in a choice of two lounges, a conservatory and a bright dining room. The centre provides residential care predominately to people over the age of 65. Twenty four hour nursing care is provided supported by a team of care staff, cleaning and laundry staff. Medical and other healthcare professionals provide ongoing health care for residents in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	22

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 4 March 2025	09:00hrs to 16:00hrs	Kathryn Hanly	Lead
Tuesday 4 March 2025	09:00hrs to 16:00hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection, carried out over one day, by two inspectors of social services. Inspectors met with three visitors and many of the 22 residents who were living in the centre and spoke with six residents in more detail. The overall feedback from residents and visitors was that Fairy Hill Nursing Home was a nice place to live and that staff were kind and caring to residents. However, inspectors had concerns about the governance and management of infection prevention and control as outlined further in this report.

On arrival, the Registered Provider Representative accompanied the inspectors on a tour of the premises. During the walk around, it was evident that the staff member was well known to residents and that they were knowledgeable regarding residents' assessed needs.

Residents were seen moving freely around the centre throughout the morning of the inspection. Many of the residents were up and dressed, while others were being assisted with their personal care by staff. The inspectors observed that staff knocked on residents' bedroom doors before entering. Some residents were enjoying a leisurely breakfast in the dining room.

Fairy Hill Nursing Home is registered to accommodate 22 residents. Bedroom accommodation was available on the ground floor with eight single bedrooms and seven twin bedrooms. Staff facilities, including, changing rooms, offices, the board room, staff room and kitchen were located on the lower ground floor.

Many residents' bedrooms were personalised with family photographs and memorabilia. Bedrooms were generally, warm, cosy and visibly clean. While the centre generally provided a homely environment for residents, the décor in some parts of the centre was showing signs of minor wear and tear and dark coloured walls made some rooms appear dark and smaller than they actually were.

The communal spaces in the centre comprised a large living room, dining room, a conservatory and a second living room which inspectors were informed was mainly used by residents and their families to celebrate birthdays and other special occasions. Many of the residents spent their day in the large living room, where residents were observed reading newspapers, watching TV and partaking in activities.

Overall, the general environment including residents' communal areas, toilets and ancillary facilities appeared visibly clean. However, some of the ancillary facilities including the sluice room and external storage shed did not support effective infection prevention and control. Findings in this regard are presented under Regulation 17; premises and Regulation 27; infection control.

Equipment viewed was generally clean with some exceptions. For example, a fridge

in the dining room was visibly unclean and residents shared manual handling slings.

Barriers to effective staff hand hygiene were also identified during the course of this inspection. Alcohol hand gel dispensers were not accessible at point of care and when the bedpan washer was turned on, there was no water supply to two clinical hand wash sinks.

The next two sections of the report, capacity and capability and quality and safety will describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). This inspection had a specific focus on the provider's compliance with infection prevention and control oversight, practices and processes.

Findings of this inspection were that further action was required by the registered provider to improve the governance and oversight of the service. There were ineffective management systems in place to identify and monitor the quality and safety of care provided to residents in particular with regard to care planning, infection prevention and control and outbreak management. Action was also required pertaining to staff training, antimicrobial stewardship and the premises to achieve regulatory compliance. These will be detailed under the relevant regulations.

Fairy Hill Nursing Home is a designated centre for older people, operated by Fairy Hill Nursing Home, Limited. At operational level, support was provided by a director of the company, representing the provider, who was present in the centre three days a week.

The person in charge (PIC) worked full-time in the centre and was supported in her role by, an assistant director of nursing, a clinical nurse manager (CNM), nurses and a healthcare team, as well as household, maintenance and catering staff. On the day of inspection, there were sufficient staffing levels and an appropriate skill-mix to meet the assessed needs of the residents.

Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre rested with the PIC. However, the provider had not nominated a staff member with the required training and protected hours allocated, to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.

A review of notifications submitted to HIQA found that COVID outbreaks had been notified to HIQA when detected over recent years. However, documentation reviewed on the day of the inspection indicated that an acute respiratory infection outbreak in January 2025 had gone undetected. This is discussed further in the quality and safety section of this report.

Surveillance of multi-drug resistant organism (MDRO) colonisation was not routinely undertaken. There was some ambiguity among staff and management regarding which residents were colonised with MDROs including several with a history of Vancomycin-resistant *Enterococci* (VRE). This meant that staff were unable to monitor the trends in development of antimicrobial resistance within the centre.

The provider had implemented a number of *legionella* controls in the centres water supply. For example, unused outlets/ showers were run weekly. However, routine testing for *legionella* in hot and cold water systems was not undertaken to monitor the effectiveness of these controls.

Infection prevention and control audits focused on hand hygiene. Other elements of standard precautions were not routinely audited. High levels of compliance were consistently achieved in recent hand hygiene audits. However, inspectors found that findings of recent audits did not align with the findings on this inspection.

A review of training records indicated that all staff were up to date with mandatory infection prevention and control training. However, findings on the day of the inspection indicated that further training was required to ensure staff are knowledgeable and competent in care planning and documentation, implementation of standard infection control precautions and on the detection and management of outbreaks. Findings in this regard are reported under the relevant regulations.

Regulation 15: Staffing

Through a review of staffing rosters and the observations of inspectors, it was evident that the registered provider had ensured that the number and skill-mix of staff was appropriate, having regard to the needs of residents and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Practices observed coupled with evidence of ineffective outbreak detection and management demonstrated that additional infection prevention and control training and supervision was required.

Documentation reviewed indicated that further training was also required in care planning and nursing documentation.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by the following:

- There was a lack of oversight of the systems in place to assure that outbreaks are detected in a timely manner.
- The provider had not nominated a staff member, with the required training, to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.
- MDRO colonisation was not routinely monitored and recorded. Staff and management were unaware that several residents were colonised with MDROs, including VRE. As a result, the person in charge could not be assured that appropriate precautions were in place when caring for these residents.
- Several elements of standard infection prevention and control precautions including sharps safety, aseptic technique, personal protective equipment (PPE) usage, equipment, environment, laundry and waste management were not routinely audited. This meant that the provider could not be assured that standard infection control precautions were consistently implemented by staff delivering care.
- Disparities between the finding of local hand hygiene audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.
- While some *legionella* controls were in place, water was not routinely tested to monitor the effectiveness of the *legionella* control programme.
- There was a lack of oversight of care plans, inspectors identified that accurate information was not recorded in resident care plans to effectively guide and direct the care residents with suspected infections. This is further outlined under Regulation 5: Individual Assessment and Care Plan.

Judgment: Not compliant

Quality and safety

Residents' rights were upheld in the centre. All interactions observed on the day of inspection were person-centred and courteous. Residents spoke of exercising choice and control over their day and being satisfied with activities available. They told inspectors that they were consulted through residents meetings on issues such as the environment, food and mealtimes and activities. There were no visiting restrictions in place. Visits and social outings were encouraged and facilitated.

Notwithstanding the positive feedback from residents and visitors, the findings of this inspection were that the impact of the inadequate governance and management of the service directly impacted on the quality of care provided to residents. Non-compliance found on inspection posed a risk to the safety and well being of residents, in particular in relation to nursing documentation, care planning, and infection control.

Residents had timely access to their general practitioners (GPs) and specialist services such as tissue viability and dietitian as required. Residents also had regular access to other health and social care professionals such as physiotherapy and chiropody.

All staff and residents were offered vaccinations in accordance with current national recommendations. Records confirmed that COVID, influenza and pneumococcal vaccinations were administered to eligible residents with their consent. However, further work was required to improve vaccination uptake among staff, as records showed that only one staff member had availed of the winter 2024 influenza vaccine.

A sample of care plans and assessments for residents were reviewed. Some care plans described resident's care needs and personal preferences in a detailed and person-centred manner, while other care plans lacked the detail required to guide staff to deliver effective, person-centred care. Action was also required to ensure that care plans were reviewed and updated at regular intervals when there was a change in the resident's condition and, following a review by health care professionals, to ensure that they effectively guided staff in the care to be provided to a resident.

A daily narrative of residents' status was recorded by day and night duty nursing staff. A review of this documentation found that staff did not document clear, accurate and timely records of resident's condition and care. These findings are detailed under Regulation 5; Individual assessment and care plan.

The volume of antibiotic use was monitored each month. There was a low level of prophylactic antibiotic use within the centre, which is good practice. However, further improvements were required to progress the antimicrobial stewardship programme. While staff were monitoring antimicrobial consumption monthly, this data was not routinely audited to inform quality improvements.

Staff were not engaging with the national "skip the dip" campaign which aimed to prevent the inappropriate use of dipstick urine testing that can lead to unnecessary

antibiotic prescribing.

All antibiotics were prescribed empirically (the initiation of antibiotics before identification of the infecting micro-organism and its antibiotic susceptibility). There was no documented evidence that nursing staff advocated for prescribing based on microbiological sample results in line with national guidelines. Details are outlined under Regulation 6.

The overall premises were designed and laid out to meet the needs of the residents. Bedrooms were personalised and residents had sufficient space for their belongings. Overall, the general environment including residents' bedrooms, communal areas and toilets appeared visibly clean.

However, a number of practices were identified which had the potential to impact on the effectiveness of infection prevention and control within the centre. For example, appropriate infection prevention and control procedures were not followed by nursing staff when collecting urine samples from indwelling urinary catheters. In addition, residents did not have allocated moving and handling slings, a fridge containing beverages was unclean and residents laundry and the bedpan washer were not managed in a way that minimised the risk of transmitting a healthcare-associated infections. An immediate action was agreed with the person in charge on the day of the inspection relating to the unclean fridge and malfunctioning bedpan washer. Barriers to effective hand hygiene practice were also identified. Findings in this regard are presented under Regulation 27; infection control.

Improvements were also required in the detection and management of outbreaks. A large number of residents developed symptoms of acute respiratory infection within the same 48-hour period in January 2025. One of these residents later tested positive for influenza while in hospital.

While the timing and clinical presentations met the case definition of an acute respiratory infection outbreak, an outbreak was not declared at this time. Several potential contributory factors were identified on the day of the inspection which impacted the early detection and control of this outbreak. For example;

- A line listing was not commenced and a Public Health Risk Assessment was not undertaken as recommended in national guidelines when residents first presented with respiratory symptoms compatible with COVID-19 or influenza.
- The Department of Public Health were not notified of a potential outbreak of acute respiratory infection when residents first presented with respiratory symptoms or other symptoms compatible with COVID-19 or influenza.
- PCR testing for influenza, COVID and RSV testing was not undertaken in line with HPSC Guidance on testing for Acute Respiratory Infection in Residential Care Facilities – Winter 2024/2025. This delayed early detection and controls and likely contributed to onwards transmission.
- Public Health and Infection Prevention and Control guidance on the prevention and management of cases and outbreaks of respiratory viral infections in Residential Care Facilities Symptomatic were not implemented when residents first presented with respiratory symptoms. For example,

symptomatic residents were not cared for with transmission based precautions and universal mask wearing was not recommended for staff during this time period.
- The rate of staff influenza vaccine uptake for the current flu season was significantly below the national uptake target of target of 75%.

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were able to meet with visitors in private or in the communal spaces through out the centre.

Judgment: Compliant

Regulation 17: Premises

The registered provider generally provided premises which were appropriate to the number and needs of the residents living there. The premises conformed to the matters set out in Schedule 6 Health Act Regulations 2013. However, the décor in some parts of the centre was showing signs of minor wear and tear. Surfaces and finishes including flooring in some areas areas were worn and as such did not facilitate effective cleaning.

There was inappropriate storage of maintenance and gardening equipment and supplies in a clinical supplies storage facility. This store was unclean which posed a risk of contamination of supplies of PPE and incontinence wear.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services.

When residents returned from the hospital, inspectors saw evidence that relevant information was obtained upon the residents' readmission to the centre.

Judgment: Compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures, consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority were implemented by staff. For example;

- An acute respiratory infection outbreak was not detected and effectively managed. The failure to identify and early rapid response to the outbreak impacted effective infection prevention and control.
- A resident in whom a diagnosis of infectious diarrhoea was suspected did not have a stool specimen sent for microbiological analysis. As a result, a potential case of infection may not have been detected and appropriate infection prevention and control measures were not implemented.
- Staff were unaware of the MDRO status of several residents. As a result appropriate control measure may not have been consistently implemented when caring for these residents.
- Nursing staff told inspectors that the dedicated sampling port was not used to collect urine samples from urinary catheters. Practices described meant that contaminated samples were obtained from drainage bags for testing. This may lead to unnecessary and inappropriate antibiotic prescribing.

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

- The bedpan washer had not been serviced in several years. This machine leaked when operating and the detergent had expired. This may impact the effectiveness of decontamination.
- There was no water supply to the hand wash sink in the sluice room or on the corridor directly outside the sluice room when the bedpan washer was operating. As a result, staff were not facilitated to wash their hands immediately after placing urinals and commodes into the bedpan washer for decontamination.
- Alcohol hand gel was not available at point of care (within bedrooms). Furthermore, inspectors found that the majority of dispensers on corridors were blocked with congealed gel. This was indicative of infrequent use.
- Individual moving and handling slings were not available for residents. Use of communal slings posed a risk of cross contamination.
- A fridge in the dining room containing beverages was observed to be unclean and mouldy. Mould can contaminate beverages leading to infections, food poisoning and gastrointestinal issues for residents.
- Laundry was not managed in a way that supported the functional separation of the clean and dirty phases of the laundering process. Clean laundry was observed to be touching dirty linen trolleys in the on-site laundry which posed a risk of cross contamination.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed residents' care documentation and found that nursing progress notes, assessment and care planning required improvement to ensure each resident's health and social care needs were identified and were accurately detailed to guide safe care. This was evidenced by:

- Daily nursing notes did not document regular monitoring of residents with symptoms of respiratory infection, including daily observations, clinical symptoms or signs of deterioration or improvement. For example, on a day where medical notes described a resident's condition as 'weak and chesty', nursing notes documented 'no new issues'. As a result, nursing staff may not have had the information they required to provide safe and appropriate care for residents.
- The majority of residents had generic infection prevention and control care plans. However, care plans were not updated to effectively guide and direct the care when resident's condition changed. For example, when the majority of residents had symptoms of respiratory infection in January 2025.
- A resident's penicillin allergy status was not documented on their drug administration record. This was a significant oversight which increased the risk of serious allergic drug reactions.
- A resident with a urinary catheter did not have a urinary care plan in place to guide their care.
- Nursing daily communication notes were not readily accessible to view and reference. Notes from recent weeks (February 2025) had been removed from the resident's file and were stored in a drawer in the nursing office while notes from January 2025 had been filed in another area of the centre.

Judgment: Not compliant

Regulation 6: Health care

The overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress. For example, while antibiotic consumption was monitored, there was no evidence to show that this data was audited or used to inform antimicrobial stewardship quality improvement initiatives.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There was a rights based approach to care in this centre. Residents' rights, and choices were respected. Residents were involved in their care and had choice in the time they wish to go to bed and when they could get up.

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 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Fairy Hill Nursing Home OSV-0005681

Inspection ID: MON-0046542

Date of inspection: 04/03/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The senior nurse has been enrolled in IPC training, with adequate hours allocated to monitor and implement best practices in IPC, within the Centre. The training will be completed by 10th of June 2025. The training session on care planning and documentation will be completed by all the nursing staff by 30th April 2025. IPC training for all the staff will be completed by 20th of April 2025.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Outbreak Preparedness: • The outbreak preparedness plan has been updated and discussed with all staff members. • HPSC (Health Protection Surveillance Centre) guidelines have been made readily available to all staff. • Important contact numbers are clearly displayed in relevant areas. • Vaccination has been actively promoted within the Centre. • Nurses have been made aware of the line listing forms for outbreak reporting. Training and Staff Awareness: • The Senior Nurse is currently enrolled in IPC training and is expected to complete it by	

10th June 2025.
• The ADON will commence IPC Link Practitioner training in October 2025.
• Staff members have been educated on outbreak management in line with evidence-based practices and are instructed to report any suspected outbreaks in accordance with national guidelines and HIQA requirements.
• Nurses have been made aware of the line listing forms for outbreak reporting.
• Documentation and care planning training for all nurses will be completed by 30th April 2025.
Supplies and Resources:
• An adequate stock of PPE, swabs, and antigen testing kits is maintained and monitored.
MDRO (Multi-Drug-Resistant Organisms) Management:
• MDRO status is now routinely monitored and recorded in residents' records.
• A surveillance list is maintained and regularly updated.
• Auditing and re-auditing are carried out to ensure ongoing compliance.
• Trending and tracing measures have been implemented to monitor the effective use of antibiotics.
All elements of standard infection prevention control precautions including:
• :
o Sharps safety
o Aseptic techniques
o PPE usage
o Equipment and environment cleanliness
o Laundry procedures are routinely audited now to ensure compliance.
• Monthly audits are conducted for:
o Antibiotic stewardship
o Infection prevention and control
o Hand hygiene
• Best practices are implemented based on audit findings.
Hand Hygiene:
• Re-auditing for hand hygiene is regularly conducted to ensure adherence to SARI guidelines.
• All staff members have received hand hygiene training.
Water Safety:
• Legionella water testing has been completed.
• A service report and risk assessment are in place to address any risks identified.
Care Planning:
• All care plans have been reviewed and updated based on findings and recommendations from the most recent inspection.
• Care plans are designed to effectively guide the management and care of residents with suspected infections.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All flooring work has been completed.
Painting work will be completed by 20th of April 2025.
The storeroom has been cleaned and is now designated solely for clinical supplies.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Outbreak Preparedness:
• The outbreak preparedness plan has been updated and discussed with all staff members.
• HPSC (Health Protection Surveillance Centre) guidelines have been made readily available to all staff.
• Important contact numbers are clearly displayed in relevant areas.
• Vaccination has been actively promoted within the Centre.
• Nurses have been made aware of the line listing forms for outbreak reporting.
• The Senior Nurse is currently enrolled in IPC training and is expected to complete it by 10th June 2025.
• The ADON will commence IPC Link Practitioner training in October 2025.
• Staff members have been educated on outbreak management in line with evidence-based practices and are instructed to report any suspected outbreaks in accordance with national guidelines and HIQA requirements.
• Nurses have been made aware of the line listing forms for outbreak reporting.
• Documentation and care planning training for all nurses will be completed by 30th April 2025.
• IPC training for all the staff will be completed by 20th of April 2025.
SPECIMEN.
Specimens are sent as needed for microbiological analysis to support the early detection of potential infections. This practice is fully implemented and actively followed.
MDRO
• Staff members are now aware about MDRO status of residents
Antibiotic stewardship training is completed on the 10/04/2025
• Residents' records are reviewed and MDRO status is updated.
Aseptic sampling
• Measures are taken for aseptic sampling procedures and dedicated sampling ports are now used for urine collection.
Environment and Equipment
• The bedpan washer has been serviced and is now in proper working condition. The detergent has been replaced to ensure effective decontamination.
• The water supply to the sinks inside and outside the sluice room has been repaired and is now fully functional.
• Hand sanitizer dispensers have been upgraded to easy-flow cartridges for better accessibility.

• Clip-on sanitizing bottles are provided for staff to ensure hand hygiene at the point of care.
• Individual slings have been allocated to each resident to minimize the risk of cross-contamination.
• A daily cleaning chart is now in place for monitoring and documenting the cleaning of residents' fridges.
Laundry Management
• A clear separation of clean and dirty laundry areas has been established to prevent contamination.
• All laundry zones are clearly labelled for easy staff identification and compliance.
• A flow chart illustrating the separation process of clean and dirty laundry phases is displayed for staff reference.
• A dedicated linen trolley is now in place, used exclusively for transporting clean clothes, further supporting infection prevention protocols.

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:
• Review of all the care plans are done and auditing and re auditing are conducted to monitor the documentation of daily observations, clinical symptoms or signs of deterioration or improvement.
• Nurses will complete care planning and documentation training by 30/04/2025.
• Generic infection control care plans are reviewed
• Penicillin allergy status is now recorded in the drug administration record.
• Urinary catheter care plans are implemented for residents with urinary catheter.
• Communication notes for the current three months are available in the nurse’s station.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Monthly audits are being conducted for antibiotic stewardship, IPC and hand hygiene, with best practices implemented according to the audit report.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	10/06/2025
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	30/04/2025
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	Not Compliant	Orange	20/04/2025

	effectively monitored.			
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.	Not Compliant	Orange	20/04/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/03/2025
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 necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	25/03/2025
Regulation 6(1)	The registered provider shall,	Substantially Compliant	Yellow	30/03/2025

	having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			