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:	New Houghton Hospital
Name of provider:	Health Service Executive
Address of centre:	Hospital Road, New Ross, Wexford
Type of inspection:	Unannounced
Date of inspection:	24 April 2025
Centre ID:	OSV-0000603
Fieldwork ID:	MON-0045275

About the designated centre

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

New Houghton hospital is situated in the town of New Ross. The building was erected in 1936 and became the fever hospital for the counties Waterford, Wexford, Carlow and Kilkenny. In 1984 the building became a care of the older person's facility. While there have been many changes, renovations and some improvements since then the design and layout of the premises is largely reflective of a small hospital from the period in which it was built. The registered provider of the centre is the Health Service Executive (HSE). The centre is registered for 42 residents over the age of 18 years, both male and female for long term care. Services provided include 24 hour nursing care with access to community care services via a referral process including, speech and language therapy, dietetics, physiotherapy, occupational therapy, chiropody, dental, audiography and opthalmic services. All admissions are planned. Residents and relatives are welcome to visit the site in advance of the placement. Residents being admitted will have been assessed by the Geriatric Assessment team and placed on a waiting list for admission. Once a bed becomes available the resident and or relative is informed and is requested to arrive to the unit before 4pm Monday to Friday. The hospital accepts all levels of dependency from level 1 (full dependency) and including residents living with dementia. The services are organised over two floors with 21 residents accommodated on each floor with a passenger lift provided. Residents' accommodation on the ground floor comprises of four, four-bedded rooms, one three-bedded room, one twin-bedded room, and one single-bedroom (end of life suite) with adjacent family/community room. All bedrooms have hand washing facilities. Residents' accommodation on the first floor also consists of four, four-bedded rooms, one three-bedded room, one twin-bedded room, and one single-bedroom (end of life suite) with adjacent family/community room. There is access to an outside suitable secure garden area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	37

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 24 April 2025	09:30hrs to 18:40hrs	Aisling Coffey	Lead

What residents told us and what inspectors observed

The overall feedback from residents was that they were happy and liked living in New Houghton Hospital. The residents spoken with were complimentary of the staff, management and the care and attention they received, with one resident summing up for the inspector by stating, "it's good here". The centre cares for a high proportion of residents with a dementia diagnosis, who were not able to speak with the inspector and give their views. Residents who could not speak with the inspector were observed to be content and comfortable in their surroundings. The interactions between staff and residents were observed to be person-centred. Staff were aware of residents' needs, and the inspector observed warm, kind, dignified and respectful interactions with residents and their visitors by staff and management over the inspection day. Visitors who spoke with the inspector provided positive feedback, referring to the high level of care and attention received by their loved ones and the communication with them as family members. While praising the service, one visitor expressed concern about access to mobile x-ray services to reduce the likelihood of their loved one having to attend the emergency department. This matter is discussed further under Regulation 6: Healthcare.

The inspector arrived at the centre in the morning to conduct an unannounced inspection, which took place over one day. During the inspection, the inspector spoke with six residents and three visitors to gain insight into the residents' lived experience in the centre. The inspector also spent time observing interactions between staff and residents and reviewing a range of documentation.

New Houghton Hospital is a three-storey building on a healthcare campus that accommodates several health and social care services in New Ross. The centre provides resident accommodation over the ground and first floors, with males on the ground floor and females on the first floor. The second floor contains a file storage area.

The main entrance to the designated centre was accessed through an open porch leading to a locked front door into a large internal lobby area. Access to the lobby was secured via keypad access, and the code was displayed at the front door to facilitate visitors. The lobby area was comfortable with domestic features, including a couch and armchair seating, a coffee table, a piano and a fish tank. From the lobby, there was access to the Abbey Unit on the ground floor and the Brandon Unit on the first floor, accessible via passenger lift and stairs.

The centre's design and layout supported residents' free movement, with wide corridors, sufficient handrails, and armchair seating within communal areas. Communal space was adequate, with residents on the ground floor having access to an open-plan sitting/dining room and the newly converted Abbey residents' lounge, previously an office facility. This lounge area housed a computer with internet access for residents to use. Residents on the first floor had access to separate sitting

and dining rooms. The centre was pleasantly decorated with artwork and photographs of residents and staff on the walls.

Bedroom accommodation on both Abbey and Brandon units comprised four four-bedded rooms, a three-bedded room, a twin room and a single room reserved to offer privacy to those residents in shared accommodation at the end of life. None of the bedrooms contained en-suite facilities, and residents shared toilet, shower, and bath facilities. These facilities consisted of two assisted showers and one assisted bath on each floor, each containing a toilet facility. The Abbey and Brandon units also had three further stand-alone shared toilet facilities. The bedrooms and assisted bathroom on each floor had ceiling tracking hoists for resident use.

Within the bedrooms, privacy curtains on overhead tracking defined the bed spaces. Each bed space had a call bell, a bedside locker, a lockable wardrobe, seating and television facilities. Within the curtained bed spaces, efforts had been made to make the environment homely, comfortable and pleasant for the residents. The inspector noted that these areas had been personalised with photographs, pictures, art and other items of personal significance to each resident. Nonetheless, due to the multi-occupancy nature of the bedrooms, residents could not carry out personal activities in private, as the privacy curtains could not exclude conversations, smells and sounds. While the provider's statement of purpose referred to earphones being available, residents spoken with informed the inspector that no earphones were provided to facilitate watching their television. Two residents described difficulties hearing the television when multiple televisions were operating in the same bedroom.

There was an onsite laundry service where residents' clothing, towels and bed linen were laundered. This area was observed to be clean and tidy, and its layout supported the functional separation of the clean and dirty phases of the laundering process. Residents spoken with were complimentary about the laundry service received in the centre.

Regarding outdoor space, the inspector found that access to the enclosed sensory garden outside the Abbey Unit sitting/dining room was restricted due to required keypad access. While the inspector observed a staff member taking one resident out to the garden, residents could not freely access this area to enjoy the outdoors. The sensory garden was a pleasant outdoor area with bench seating, a gazebo, a pergola, and raised flower beds. However, as discussed later in the report, the garden needed post-winter maintenance, repairs and further works identified by the person in charge to ensure it was a safe and comfortable area for residents and visitors to enjoy.

This garden was also the designated area for residents who chose to smoke and was seen to have the necessary protective equipment for residents who smoked, including an ashtray and a nearby fire extinguisher. The person in charge informed the inspector that the residents brought a pendant alarm call bell to the garden in case assistance was required.

While the centre was generally well maintained and clean throughout, some areas were experiencing wear and tear, requiring redecoration and repair, while other areas required review to ensure residents were protected from infection. These findings will be discussed further within the report.

Residents were up and dressed in their preferred attire and appeared well cared for on the morning of inspection. Residents freely mobilised around the centre, watching television, reading the newspaper, knitting, drawing, and chatting with other residents and staff.

The provider had 2.51 whole-time equivalent activity staff working in the centre. Activities were scheduled to take place over seven days and throughout the centre. Residents told the inspector they liked bingo and arts and crafts. Some residents told the inspector that they did not wish to participate in group-based activities and were seen to relax at their bedsides, watching television, reading, or chatting with staff, as per their preferences. On the morning of the inspection, the inspector observed a lively bingo game on the ground floor involving 11 residents. The inspector was informed that an exercise class took place after lunch in the first-floor dining room. Outside these times, residents were seen sitting for lengthy periods in the sitting rooms with staff present and the television on, but without other meaningful activation.

Meals were served in the open-plan sitting/dining room in the Abbey Unit and a separate dining room in the Brandon Unit. The centre had two sittings, the first for residents requiring mealtime assistance at 12:20 pm and the second for residents independent at mealtimes at 1:00 pm. Residents who required assistance at mealtimes were observed to receive this support in a respectful and dignified manner.

Meals were prepared off-site and brought to the centre. The inspector saw a four-week rolling menu. The menu had three main course options daily for standard and modified consistency diets. On inspection day, the main course options were chicken, lamb, and pork. Residents confirmed they were offered a choice of main meal the evening beforehand, and the inspector reviewed this documentation. The food served appeared nutritious. However, there were a small number of complaints that the "lamb was tough". Residents expressed a neutral response when asked about the food. Some residents described the food as "ok', "alright", and "grand", while another resident told the inspector that "some days it's nice".

The inspector spent time with the catering team reviewing written documentation received from the nursing team on residents' dietary needs and food preferences. The inspector observed that there were ample drinks available for residents at mealtimes, and further beverages were accompanied by snacks throughout the day, including a tea and soup round at 10:30 am, a further tea round at 3:00pm, and an evening meal at 4:30pm. Catering staff confirmed to the inspector that supper was at 7:00pm, and sandwiches, yoghurts, fruit, custard, buns, and cakes were served with further refreshments.

The inspector witnessed mixed finding in relation to the dining experience in the centre. While residents of the Brandon Unit had a separate dining room there was no separation of the dining and sitting areas on the Abbey Unit. This meant that the male residents on Abbey Unit waiting for the second lunch sitting were seated both alongside and observing residents eating at the first sitting. This arrangement was seen to cause agitation for one resident who expressed dissatisfaction at having to wait for their meal while other residents ate. Space was also limited during dinner time in Abbey Unit, with 16 male residents and staff in the sitting/dining room while three other gentlemen ate at their bedsides, aligned with their preferences. The space limitations meant that not all Abbey residents could eat at a dining table. Three residents were seen eating from mobile bed tables, while four residents ate their meal from low circular tables while seated in their armchairs, which were positioned against the wall. These four residents were observed bending over to reach their food on these low tables. In contrast, the residents of Brandon Unit arrived to the dining room where their meal was promptly served. They had a relaxed, sociable dining experience with ample space to dine comfortably, while seated at a dining table and enjoying the company of staff and other residents. The Abbey Unit dining experience will be referenced further in the report under Regulation 18: Food and nutrition.

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

Capacity and capability

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

This was an announced inspection to assess the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended) and to review the registered provider's compliance plan arising from the two previous inspections in 2024. The provider had a history of non-compliance with Regulation 28: Fire precautions in the January and April 2024 inspections and a restrictive condition had been attached to the centre's registration certificate requiring the provider to conclude exploratory fire safety works and complete the works required to create two 60 minute fire rated compartments on each floor of the centre by 31 December 2024. The provider had communicated with the Office of the Chief Inspector to notify them of the completion of these works. This inspection, therefore, also informed a decision regarding the removal of this

condition of registration. The inspector also followed up on one piece of unsolicited information that had been submitted to the Chief Inspector since the last inspection. This information was related to records of a resident discharged from the centre, and the findings are discussed in the report under Regulation 21: Records.

The registered provider had progressed with the compliance plan, and significant improvements were identified in governance and management, premises, fire precautions, records, written policies and procedures, food and nutrition and residents' rights. Following this inspection, further improvements were required concerning several regulations, including training and staff development, as outlined in the report.

The registered provider is the Health Service Executive (HSE). There was a clearly defined management structure with identified lines of accountability and responsibility for the service. Within the centre, there have been some changes in governance and management, including a change in the person in charge since the last inspection. The current person in charge, an experienced nurse manager, has been in the position since 24/02/2025. The person in charge worked full-time in the centre and was supported by the manager of older persons' services, who represents the provider for regulatory matters and attended the onsite feedback meeting at the end of the inspection. The person in charge also oversees a day centre, which is not part of the designated centre but is located on the same healthcare campus. Regarding the designated centre, the person in charge was supported by five clinical nurse managers, four dedicated to the day-to-day running of each unit, and one as a practice development clinical nurse manager. One of these clinical nurse managers deputised for the person in charge when they were absent. Further care and support was provided to residents by a team of nurses, healthcare assistants, catering, activities, housekeeping and administrative staff.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2024. The inspectors saw evidence of consultation with residents and families reflected in the review. The inspector also reviewed the quality improvement plan, developed to address the issues highlighted by the annual review which was seen to be in progress.

Regarding staffing, the inspector reviewed past and future rosters covering a three-week period and found the provider relied heavily on agency personnel to maintain staffing levels in the centre, particularly at night. On multiple shifts examined, there were more agency nursing and healthcare assistant staff than the provider's directly employed staff. In general, however, the same agency staff were listed on the rota, indicating the provider's efforts to seek continuity of personnel and consistency of support required for residents. While there were sufficient staff on duty to meet the needs of residents living in the centre on both inspection days, the negative impact of the over-reliance on agency staff created other risks in the service, which are discussed under Regulation 16: Training and staff development.

A comprehensive training programme was available to the providers' directly employed staff to support them in their roles. Records reviewed showed these staff had completed training on safeguarding vulnerable persons from abuse, fire safety

training, responsive behaviour, manual handling and medication management. The person in charge had recently developed a comprehensive induction checklist for agency nursing and healthcare assistant staff that was being rolled out at the time of inspection. Notwithstanding this good practice, the oversight of agency staff member training in respect of fire evacuation needed robust improvement, and this will be discussed under Regulation 16: Training and staff development.

There was documentary evidence of communication between the manager of older persons' services and the person in charge of the centre. Similarly, within the centre, there was evidence of communication between the person in charge and staff at the ward level. During these meetings, key issues relating to the quality and safety of the service delivered to residents were discussed, such as premises, facilities, incidents, safeguarding matters, complaints, regulatory compliance, staff training, health and safety and infection control.

The provider had multiple management systems to monitor the quality and safety of service provision. The provider collated data regarding care delivery via an audit schedule and nursing metrics, which examined key areas, including infection control, the use of restraint, falls prevention and residents' nutritional needs. A risk register was used to monitor and manage known risks in the centre. The provider also had a system for recording, monitoring, and managing incidents and related risks. Records reviewed found that incidents like falls were being analysed on an individual resident basis to identify causal factors to reduce risk to that resident. These incidents were also being analysed collectively to track and trend reasons for the falls and to circulate learning among staff. While acknowledging these good practices, this inspection found that some management systems needed enhancement to identify further deficits and risks in service provision and to drive sustained quality improvement when risk was identified. These matters will be discussed under Regulation 23: Governance and management.

The provider had a record management system in the centre, and records were securely and safely stored. However, there were some gaps in records that were required to be kept in the centre. These matters are discussed further under Regulation 21: Records.

There were two volunteers available in the centre who provided a valuable service for residents. Volunteers' files and other records showed that the provider had obtained a Garda Síochána (police) vetting disclosures for the volunteers and that they received supervision and support. While noting this good practice, some improvements were required to comply fully with the regulation, which will be outlined under Regulation 30: Volunteers.

Regulation 14: Persons in charge

There was a new person in charge who met the requirements of the regulations. They are an experienced registered nurse with previous management experience of being in charge of another designated centre. The person in charge demonstrated

good knowledge and understanding of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and their regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

Based on a review of the worked and planned rosters and from speaking with residents, sufficient staff of an appropriate skill mix were on duty each day to meet the assessed needs of the residents. At night, there were two registered nurses in the centre. While the provider relied heavily on agency personnel to maintain staffing levels in the centre, clear efforts were observed to support continuity of care, as seen on the rosters.

Judgment: Compliant

Regulation 16: Training and staff development

The provider's directly employed staff had access to a suite of training programmes to enable them to perform their respective roles. Compliance with mandatory training among the provider's directly employed staff was good. However, agency staff were not included in the provider's training matrix. The provider had written agreements with recruitment agencies that agency staff had completed mandatory training. However, given the provider's heavy reliance on agency staffing, with many shifts being predominantly covered by agency staff, further assurances were required regarding agency staff training on centre-specific procedures and resident safety equipment.

For example, following the last two inspections, in January and April 2024, which found that all staff had not been trained to facilitate a vertical evacuation using the stairs, the provider arranged this training for their directly employed staff in May 2024, which covered the use of newly purchased ski sled evacuation aids. Similarly, in December 2024, the provider had trained their directly employed staff on how to use the upgraded fire evacuation lift. However, there were no records or assurances that any agency staff had completed these trainings.

The inspector reviewed nursing and healthcare assistant staffing rosters for a three-week period, 14/04/2025 - 04/05/2025. From examining these rosters, it was evident that on the first floor at night, agency staff covered all of the healthcare assistant shifts in that period and 19 of the 21 nursing shifts. The inspector spoke with four agency staff on the inspection day. All four staff confirmed they had not received training on the use of the evacuation lift, while two stated they had not

received training on using the ski sleds. Given the provider's heavy reliance on agency staffing, assurances are required that agency staff are trained to use the evacuation lift and the ski sleds.

Judgment: Not compliant

Regulation 21: Records

A review of six personnel files found evidence of the staff member's identity, Garda Síochána (police) vetting disclosures, documentary evidence of relevant qualifications and current registration details. However, some improvements to records were required to ensure that personnel files contained all of the documentation required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). For example:

- One personnel file did not contain a full employment history, while three other files had gaps in the staff member's employment history.
- One staff member did not have a reference from their most recent employer.

The inspector also reviewed records of residents transferred to and from the acute hospital and saw that the provider had a comprehensive template document to support this process. However, the inspector found one example where a full copy of the correspondence concerning a resident transferred to the hospital was not retained in the centre, as required by the regulation.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the provider had management systems to monitor the quality and safety of service provision, these oversight mechanisms required improvement to effectively identify deficits and risks in service provision and to continuously drive sustained quality improvement when risk was determined, for example:

- The provider's assurance systems had not been fully effective in identifying risks in training and staff development, infection control, fire precautions, residents' rights, managing behaviour that is challenging, premises and healthcare found during this inspection.
- The provider's risk management systems had not identified the risk of access to the flat roof area from the first-floor corridor in two locations. While two doors from the first-floor corridor to the flat roof area below were locked, the key to both of these doors was in an adjacent key box that was opened by

the inspector without inputting a code. Additionally, the door restrictors on both doors were seen to be broken.

Judgment: Substantially compliant

Regulation 30: Volunteers

There were two volunteers operating in the centre. Both volunteers had Garda Siochana (police) vetting disclosures on file and were supported and supervised by the activity coordinator or clinical nurse manager when onsite. However, at the time of inspection, the volunteers did not have their roles and responsibilities set out in writing. The person in charge submitted an updated volunteer policy after the inspection, which defined the volunteer roles.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policies required by Schedule 5 of the regulations were in place, updated in line with regulatory requirements and made available to staff in the centre.

Judgment: Compliant

Quality and safety

While the inspector observed kind and compassionate staff treating residents with dignity and respect, enhanced governance and oversight were required to improve the quality and safety of service provision. Some improvements were required concerning healthcare, managing behaviour that is challenging, residents' rights, premises, infection control and fire precautions.

Residents had access to medical, mental health, specialist nursing and various allied health services, such as speech and language therapy, occupational therapy and dietitian services within the centre. The records reviewed showed evidence of ongoing referral and review by these healthcare services for the residents' benefit. However, the inspector found that action was required to ensure all residents received a high standard of evidence-based nursing care and timely access to mobile x-ray services, as discussed further under Regulation 6: Healthcare.

The majority of staff members had completed training on managing challenging behaviour. Residents predisposed to episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) had a responsive behaviour care plan and other documentation to guide staff. Records reviewed found that behaviour observation charts, such as the Antecedent, Behaviour, and Consequence charts, were also being used to understand the behaviour and respond in a manner that was not restrictive. Restraints used in the centre were risk assessed, and there was evidence that alternatives had been trialled. Notwithstanding these good practices, two registered nurses required training, and there continued to be restricted access to the garden outside the Abbey Unit sitting/dining room due to the need for maintenance works to enhance the safety of this facility. These findings are discussed under Regulation 7: Managing behaviour that is challenging.

The inspector observed staff being respectful and courteous towards residents. Staff were seen to respect residents' privacy and dignity by knocking on bathroom doors before entering. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents' meetings and completing residents' questionnaires. In response to residents' feedback, the provider planned to use a bus to facilitate regular day trips and outings. Resident questionnaires were seen to have been analysed, and an action plan was in progress. The centre had monthly religious services available in-house. Residents could communicate freely and had access to radio, television, newspapers, telephones and internet services. The provider was in the process of attempting to boost the internet signal in the centre by installing additional routers. Residents also had access to independent advocacy services. While acknowledging these good practices, further improvements were required to residents' rights, as discussed under Regulation 9.

Concerning the premises, the inspector observed that residents' bedrooms were clean, tidy and personalised with items of importance to them, such as family photos and sentimental items from home. Residents had space to store their clothes, toiletries, and other belongings and display significant possessions. Each resident had access to lockable storage. The centre had communal spaces for residents and their visitors to use. There was an on-site laundry set up to support the functional separation of the clean and dirty phases of the laundering process. While noting these positive aspects, some improvements to storage arrangements were required in addition to maintenance and repair to ensure the premises fully complied with Schedule 6 requirements, including the requirement for a sufficient number of toilets. These matters will be discussed under Regulation 17: Premises.

Residents spoken with expressed a neutral response when asked about the food available. Food was prepared and cooked off-site and delivered to the centre. Choice was offered to all residents mealtimes, and adequate quantities of food and drinks were provided during the day. Residents had access to fresh drinking water and other refreshments throughout the day. Residents' dietary needs, as prescribed by a dietitian or speech and language therapist, were seen to be met. There was adequate supervision and discrete, respectful assistance at mealtimes. An area

requiring improvement related to the dining experience on Abbey Unit, which will be discussed under Regulation 18: Food and nutrition.

The provider had systems to oversee the centre's infection prevention and control (IPC) practices. The provider had four registered nurses trained as IPC link practitioners to guide and support staff in safe IPC practices and oversee performance. The environment was generally clean and tidy. The provider used a tagging system to identify equipment that had been cleaned. Items in the store rooms were seen to be off the ground and on shelving. There was surveillance of antibiotic consumption in the centre. A targeted infection control auditing programme was undertaken. While acknowledging these good practices some areas required attention to ensure residents were protected from infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018), other national guidance in relation to IPC and to ensure staff had suitable training, as set out under Regulation 27: Infection control.

The provider had undertaken significant action to improve fire safety since the last two inspections in January 2024 and April 2024. This inspection found that the provider had robust arrangements to detect, contain, and extinguish fires. Preventive maintenance for fire detection, fire-fighting equipment and emergency lighting was conducted at recommended intervals. The electrical installations had been inspected in November 2024. There were records of daily visual checks on the fire alarm panel, fire extinguishers, emergency lighting, escape routes and fire doors and weekly checks on fire precautions and hazard controls. Fire doors were observed to be in good working order. The provider's staff received annual fire safety awareness training and further training on using evacuation sleds to facilitate a stairs evacuation and using the upgraded fire evacuation lift. There were evacuation aids for residents in the two stairwells in the centre to facilitate a vertical evacuation. Each resident had a personal emergency evacuation plan, and fire compartment maps were displayed prominently in the centre to guide staff in an emergency requiring evacuation. Fire drills were conducted regularly and covered a range of evacuation scenarios, including a lift evacuation and the use of the evacuation ramp. Residents who choose to smoke do so in a designated area containing safety equipment. While there was evidence of these good practices, some further actions were required to ensure the safety of residents in a fire emergency. These findings are set out under Regulation 28: Fire precautions.

Regulation 11: Visits

The provider had a written visitor policy. The inspector observed that visits to the centre were encouraged. The visiting arrangements in place did not pose any unnecessary restrictions on residents. The registered provider had a newly designated private visiting area for residents to receive a visitor if required.

Judgment: Compliant

Regulation 17: Premises

While the premises were generally maintained to an acceptable standard, some areas required maintenance and repair to be fully compliant with Schedule 6 requirements, for example:

- The garden outside the Abbey sitting/dining room was seen to require post-winter maintenance and repairs as the inspector saw a broken waste pipe, a broken water feature, and a bird feeder insecurely leaning against a garden gate. Additionally, there were further outstanding works in relation to the pathways and the garden gates identified as necessary by the person in charge to ensure the area was safe and comfortable for residents and visitors to enjoy. While these works were awaited, the residents did not have unrestricted access to the garden.
- The flooring in the Abbey sitting/dining room had significant indentations, making it difficult to clean effectively. This is a repeat finding from the January 2024 and April 2024 inspections. The person in charge and the provider representative confirmed a request for new flooring had been escalated within the agency.
- The inspector observed areas of damp in some window reveals where residents displayed their possessions in their bedrooms, including the first-floor bedroom 1 and the ground-floor bedroom 2. There was mould growth and paint and plaster flaking from the wall, resulting in dust deposits.
- Door restrcitors on two doors leading out to the flat roof area from the first-floor corridor were seen to be broken.
- There was no call bell in the Abbey residents' lounge.

There was inappropriate storage seen in the centre, for example:

- A comfort chair belonging to a deceased resident is being stored in the first-floor dining room.
- Laundry skips, linen trolleys and wheelchairs were being stored in the assisted shower rooms.

The registered provider had not ensured sufficient functioning toilets for the residents on the ground floor. The 13 residents of bedrooms 3, 4, 5 and 5a on Abbey unit had access to three toilet facilities, one in the bathroom, one in the shower room and one standalone toilet facility. The inspector found the standalone toilet had signage on the door stating it was a visitor's toilet, while the toilet in the bathroom was observed to be leaking and had a safety barrier blocking access to the toilet. This meant that 13 residents were sharing one functioning toilet. This was brought to the attention of the person in charge, who confirmed the signage for the visitors' toilet would be removed and that the leaking toilet had been escalated to the maintenance department.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector observed the dining experience on each floor on the inspection day. While the residents of Brandon Unit had a pleasant, comfortable and sociable dining experience, improvements were required in how meals were served on the Abbey Unit, for example:

- The Abbey Unit did not have a separate sitting and dining area. As there were two sittings, the male residents on Abbey Unit waiting for the second lunch sitting were seated both alongside and observing residents eating at the first sitting.
- Space was also limited during dinner time in the Abbey Unit, meaning that all residents wishing to eat communally could not sit at a dining table. Three residents ate from mobile bed tables, while four residents were seen bending over to eat from low circular tables while seated in armchairs positioned against the wall. This did not afford residents the opportunity to have their meal served on a dining table with the opportunity for social engagements with other residents and staff over their meal.

The person in charge and the provider representative informed the inspector of a project that would be taking place to enhance aspects of the dining experience.

Judgment: Substantially compliant

Regulation 27: Infection control

While the interior of the centre was generally clean on the day of inspection, there were some areas for improvement relating to the management of the environment and resident equipment identified to ensure residents were protected from infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018), other national guidance in relation to IPC and to ensure staff had suitable training.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection, for example:

- The first floor housekeeping room did not contain a janitorial sink. Housekeeping staff confirmed that water for cleaning purposes was accessed from the adjacent sluice room. This posed a risk of cross-contamination. This was a repeat finding dating back to the June 2023 inspection. The person in charge and the provider representative confirmed that a request for a janitorial sink on the first floor had been escalated within the agency.

- The layout of two sluice rooms required review as commodes labelled as clean were seen to be stored beside and blocking access to the bedpan washer on the ground and first floors.
- The decontamination of resident care equipment required review, as a sample of crash mats was observed to be visibly dirty with dried-in liquid stains and other debris.

Staff training required review to ensure all staff received suitable infection prevention and control (IPC) training. A review of the provider's staff training records indicated high compliance rates with hand hygiene, personal protective equipment (PPE), and sharps management. However, there were poor compliance levels with other IPC programmes identified by the provider, including the basics of IPC, cleaning and disinfecting the healthcare environment and residents' equipment, the management of linen and waste, healthcare-associated infections and antimicrobial resistance.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While significant work had been completed to protect residents against the risk of fire, the oversight of fire safety within the centre required review to ensure continued resident safety.

Precautions against the risk of fire required review, for example:

- The provider had arranged for the electrical installations to be inspected in November 2024; however, further assurances were required that four urgent actions arising from this inspection had been completed.
- A battery charger and a clinical monitoring machine were connected to the electricity supply in the ground-floor linen room, adjacent to large stocks of towels and sheets. Charging items adjacent to combustible materials created a risk of fire.
- The store room, known as 'the Shop', had electrical panels and other cablings at a high level. Items were being stored on shelving near these electrical panels. While the person in charge had completed a risk assessment, further risk assessment by a competent person was required to determine the appropriate controls required to manage the risk when using this area for storage.
- While the provider had a system for checking that the gas cooker pilot light was extinguished each evening, the inspector found the pilot light in the kitchen was left on while the kitchen was unattended. This practice required review to ensure the appropriate controls were in place.

The registered provider's arrangements for maintaining means of escape required review, for example:

- On the ground floor, one horizontal escape route led into the enclosed garden outside the Abbey sitting/dining room. The garden was secured with three padlocked gates. All staff spoken with confirmed they did not know how to unlock the padlocked gates, meaning onward escape from the garden could be delayed in an emergency.
- The provider had upgraded their passenger lift to a fire evacuation lift; however, there was confusion among some of the staff regarding the location of the lift key, which could delay a lift evacuation in an emergency.

The registered provider arrangements for containing fire required review, for example:

- The provider had installed four new sets of fire doors, two cross-corridor doors and two compartment doors. Floor plans provided to the Chief Inspector indicated that these were 60-minute fire doors, rated FD60; however, the signage on three of the four door sets stated that they had a 30-minute rating, rated FD30S. The provider representative undertook to seek clarification on this matter.

While fire drills were conducted regularly and covered a range of scenarios, the provider could not be assured that residents in the centre could be evacuated in a timely manner, as some evacuation approaches had not been practised. For example, the inspector reviewed fire drill records since the last inspection in April 2024 and noted stairs evacuation had not been practised in the drills. The provider submitted two stairs evacuation drill reports, which took place after the inspection.

Findings in relation to agency staff training on evacuation procedures, specifically the use of ski sleds and the evacuation lift, are outlined under Regulation 16: Training and staff development.

Judgment: Substantially compliant

Regulation 6: Health care

Notwithstanding residents' access to a range of healthcare professionals, some improvement was required to ensure that all residents had timely access to appropriate professional expertise based on their assessed needs and a high standard of evidence-based nursing care. For example:

- The inspector reviewed the records of two residents who had unwitnessed falls and found neurological observation assessments were not monitored and documented in line with the provider's falls policy. The inspector found that there was no record of any neurological observation assessments after these two falls. Neurological observations allow for early identification of clinical

deterioration and timely intervention. Not completing the neurological observations may lead to delays in recognising a resident at risk of clinical deterioration.

- Action was required to ensure that all residents had timely access to mobile x-ray services. Several staff members and a relative spoken with confirmed this service was not accessible to residents of the centre when clinically indicated by a doctor. The provider representative confirmed at the feedback meeting that there was access and undertook to ensure the referral pathway was known to relevant staff.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Management had not recognised the restricted access to the enclosed secure gardens, which was not in line with the national policy, *Towards a Restraint Free Environment in Nursing Homes,* published by the Department of Health. There continued to be restricted access to the garden outside the Abbey Unit sitting/dining room, a repeat finding from the January 2024 inspection. The door to the enclosed garden was locked, requiring a keypad code, meaning residents could not freely access this area to enjoy the outdoors. While this restriction was risk assessed, the required actions were maintenance works identified by the person in charge in respect of the pathways and the garden gates, which had yet to be completed. While these works were outstanding, the residents did not have unrestricted access to the garden.

Records reviewed found that while the majority of the provider's directly employed staff had undertaken training in managing behaviour that is challenging, two registered nursing staff out of 16 nursing staff were required to undertake this training.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While many aspects of residents' rights were upheld in the centre, some improvements were required to ensure residents' privacy and dignity in their bedrooms, as the inspector observed one bedroom door, the end of life room on the ground floor, had clear glass windows fitted, allowing an unobstructed view into residents' bedrooms. There were no further privacy screens or curtains in the bedrooms, which meant this resident could not undertake personal activities privately in their bedrooms.

The provision of activities observed for residents did not ensure that all residents had an opportunity to participate in activities in accordance with their interests and capacities. While group-based activities took place on the ground floor in the morning on the inspection day and on the first floor in the afternoon, residents were also seen sitting for lengthy periods in the sitting rooms with staff present and the television on, but without other meaningful activation.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for New Houghton Hospital OSV-0000603

Inspection ID: MON-0045275

Date of inspection: 24/04/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Regular agency staff are included in our site specific fire training including vertical evacuation procedure. 12 regular agency staff members has been provided with such training in 2025. Further regular agency staff will be encompassed within the 2025 training schedule to include use of ski sleds and the operation of the lift in case of a fire. • Ward rosters now highlight the staff who have completed fire training to visually identify that appropriate support is in place to the first floor for all shifts. This is monitored by the Person in Charge. Completion Date: 30/11/2025	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • All Nursing Staff have been reminded to retain a copy of all transfer documents and correspondence in line with the regulatory requirement. Clinical Nurse Manager's will monitor compliance with same. • The centre's induction for agency nurses/new staff has been updated with the mandatory requirement to retain copies of all discharge/transfer documents on file. • The personnel file that did not contain a full employment history is now updated and complete. This related to a staff member who has been employed by the centre for over twenty years.	

• The three personnel files with minor employment gaps are now updated and completed.

• A reference has been requested for the one staff member who did not have a reference from a recent employer on file. This staff member has been employed by the centre for over 15 years.

Completion Date: 31/07/2025

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
With regard to the specific risk areas identified please see as follows:

• Regular agency staff are included in our site specific fire training including vertical evacuation procedure. 12 regular agency staff members has been provided with such training in 2025. Further regular agency staff will be encompassed within the 2025 training schedule to include use of ski sleds and the operation of the lift in case of a fire. Completion date 30/11/2025.

• A robust Infection Prevention & Control programme of training is ongoing. Completion Date: 31/08/2025

• Further training on managing behaviour that is challenging is scheduled to take place on the 14th of July. The two staff members noted in the report are both schedule to attend same. The centre now has two in-house trainers which will allow regular and iterative training in this area to be delivered. Expected completion: 14/07/2025

• A site meeting is planned for 10/07/2025 with multi-disciplinary input from nursing, IPC, Fire Officer, Maintenance & Health and Safety to review the suitability and risk assess a proposed location of a janitorial sink on the First Floor. Should the location be considered appropriate, works will be expedited with an expected completion date of 31/08/2025 barring any unexpected requirements e.g. structural works.

• The door restrictors on doors leading to the external roof area on the First Floor have been repaired. The key to these doors is accessed via a locked key safe which is monitored and checked by the charge nurse on the ward as part of documented daily safety checks. Complete 03/07/2025.

As regards to the centre's management & oversight systems, the provider has taken the following steps to improve and embed a system-wide approach to governance, quality

assurance, and risk management:
• Management Reporting
In addition to the established quarterly hospital governance meetings, the Person In Charge will now provide a written governance report at the midpoint between such meetings to the Provider Representative which will demonstrate such information audit outcomes, incidents & complaints, access and compliance for mandatory training, resident feedback and updates on quality improvement plans. The report will follow the same format as the established standing agenda for the hospital governance meetings. For Implementation: 30/08/2025

• Risk & Incident Management Processes
The centre's Risk Register is reviewed quarterly with support from a qualified Quality & Patient Safety Advisor.
The key access and roof area issue has prompted a wider review of physical security risks in the premises and approval has been granted for the installation and commissioning of CCTV to monitor external doors for resident & staff safety. Expected installation completion: 30/08/2025.

• Compliance Action Plans
The commitments to quality & service improvement plans at the centre are captured in defined compliance action plans to ensure timely management and progression.

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
• All volunteers have received a copy of the updated volunteers policy to outline their role and responsibilities. Complete 03/07/2025.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A thorough review of the sensory garden has taken place by Nursing, Occupational Therapy, Health & Safety and an external Garden Maintenance company with a view of enhancing the safety and experience for residents using the garden. Residents were also surveyed on how they would like the garden to be developed – from this additional plants and a vegetable patch have been installed. Pathways in the garden have been power washed and general post-winter maintenance works are ongoing. Any broken equipment have been removed or replaced; the gazebo has been repaired and painted and approval has been sanctioned for the repair or replacement of the wooden posts

around the raised beds. Expected Completion date 31/08/2025.
• As part of the MDT review of the sensory garden, specific assessment of the height of the fence and gate were requested. It was determined by the group that to raise the fence/gate would impact negatively on the resident's enjoyment of the garden and become restrictive in nature. The provider is currently sourcing natural tree screening to supplement the fencing to both enhance the environment and provide additional security to the unit. CCTV has also been approved for installation to monitor external doors to further enhance resident safety and this will be installed by 30/08/2025. These measures will further mitigate the risk of absconsion and support access for residents.
• The Health & Safety Officer has provided advice and support to the centre as regards individual risk assessment for residents having unrestricted access to the garden on such grounds as mobility, falls risk, absconsion risk. This will include consideration of the underlying psychical or psychological factors of the person's risk profile, all alternative measures trialed and outcomes. Appropriate clinical assessments are completed for each resident such as Multi Factorial Falls Risk Assessments to identify, mitigate and manage such risk.
• These individual risk assessments are currently underway. Where residents are identified as having low/limited risk they will supported with unrestricted access to the garden. Those of a higher risk will be facilitated with supervised access to the garden on request and will be encouraged to avail of same on a regular basis by the activities and care team. Completion date: 31/07/2025
• As part of the Health & Safety Officer's recommendations, the centre is sourcing quotations for handrails for the sloped portion of the garden to further reduce the risk of falls which should reduce risk to a larger proportion of residents and support free access to the garden. Expected Completion date: 30/09/2025.
• As an interim support while awaiting the additional handrails, CCTV and tree screening, the Dayrooms are supervised and the doors are left open as weather permits. Once the above measures are in place it is intended to disable the key pad lock during day time hours.
• The activity team also encourage all residents to enjoy the garden and support same to greatest extent – for instance the evening meal was held in the sensory garden last week which received excellent feedback.

• Approval has been granted for the repair and replacement of flooring in the Abbey Sitting/Dining Room and a start date is awaited for same. Expected completion date: 30/09/2025.

• The window reveals in Bedroom 1 on Brandon and Bedroom 2 on Abbey have been treated and painted. Window reveals have been added to the housekeeping cleaning schedule. Complete 03/07/2025.

• The door restrictors on doors leading to the external roof area on the First Floor have been repaired. Complete 03/07/2025.

• All unused comfort chairs have been removed from the centre. Some chairs may be suitable for reassignment to other residents and are reassessed and adjusted to the resident's specific need by an Occupational Therapist. Complete 03/07/2025

• A site meeting is planned for 10/07/2025 with multi-disciplinary input from nursing,

IPC, Fire Officer, Maintenance & Health and Safety to review appropriate storage solutions for the laundry skips, linen trolleys and wheelchairs. The recommendations from the review will be actioned appropriately. Expected completion date 30/09/2025.

• A nurse call bell is installed and is in working order in the Resident's Lounge in Abbey Unit. Complete.

• All toilets on the ground floor are for the use of residents and are in working order. There is no signage indicating these are visitor facilities. Complete 03/07/2025.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• A 2025 Quality Improvement Programme – "Dining with Dignity" is underway at the centre. An initial training session was carried out by a trained dysphagia chef with a background in hospitality to support an enhanced dining experience for residents with a focus on presentation of meals for those on modified diets. Expected Completion: 31/10/2025
• A review of the dining experience in Abbey has taken place, further to discussion with residents as to their preferences. In line with the resident's feedback, residents for the first sitting are seated to one side of the dining/sitting room and the second seating to the other side so as to ensure a relaxed, unrushed dining experience. This will be kept under review and feedback from resident will be sought in August 2025. Complete 03/07/2025
• Residents are encourage to move to the dining table for meals but where they express a preference to remain in their comfort chair/arm chair in their preferred spot, the team will facilitate their wishes through the provision of a mobile bed table. Complete 03/07/2025.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• A site meeting is planned for 10/07/2025 with multi-disciplinary input from nursing, IPC, Fire Officer, Maintenance & Health and Safety to review the suitability and risk assess a proposed location of a janitorial sink on the First Floor. Should the location be considered appropriate, works will be expedited with an expected completion date of 31/08/2025 barring any unexpected requirements e.g. structural works.

• A review of the sluice rooms has taken place and only 2 commodes are now stored in the smaller sluice rooms in both units to ensure access to bedpan washers and avoid cross contamination. Complete 03/07/2025.
• Crash mats and Bedrail bumpers are audited weekly and the cleaning schedule has been updated with daily cleaning of crash mats. Complete 03/07/2025.
• A robust Infection Prevention & Control programme of training is ongoing. Completion Date: 31/08/2025

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The four actions arising from the Periodic Electrical Inspection Report have been addressed and completed. Complete 03/07/2025.
• The battery charging unit and Vital Signs Monitoring Machine have been removed from the linen store and notice placed in the linen store to alert staff that no items are to be left charging via electrical sockets in the linen room. This will be monitored through daily fire safety checks. Complete 03/07/2025.
• The Shop was assessed by the Fire Officer and recommendations around the removal of items stored on shelving have been completed. Complete 03/07/2025.
• The pilot light on the gas cooker is now turned off after each use and re-lit as needed. This has been updated on the daily kitchen safety checklist. Complete 03/07/2025.

• Codes for the three gates in the garden and location of the lift key box next to the lift are documented on the Safety Pause document displayed in the nurses station, included in the induction checklist and daily handovers. Knowledge of the codes or where to find them and the lift key will be monitored as part of fire drills. Complete 03/07/2025.

• Confirmation have been provided by the fire door installers that the new fire doors are rated FD60 and appropriate certification has been placed on the door and supplied to the regulator. Complete 03/07/2025.

• Fire drill schedules have been updated to ensure all evacuation methods are practiced in rotation – Horizontal, Vertical Ramp evacuation, Vertical Stair evacuation and Vertical Lift evacuation. Complete 03/07/2025.

• Regular agency staff are included in our site specific fire training including vertical evacuation procedure. 12 regular agency staff members has been provided with such training in 2025. Further regular agency staff will be encompassed within the 2025 training schedule to include use of ski sleds and the operation of the lift in case of a fire. Completion date 30/11/2025.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The importance of comprehensive post fall assessment, documentation and indicated observations has been reiterated to all HSE and agency nursing staff and is highlighted at Safety Pauses. Further education on the falls policy has been provided to the team. The Clinical Nurse Manager at each unit completes a post fall investigation on each fall to identify and address any gaps in the documentation. The Person in Charge reviews these post fall investigation to ensure a robust system of oversight.
• Access to Mobile Xray is provided to residents at the centre where ordered by the Centre's Medical Officer.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• There is unrestricted access to the dining areas for all residents. Complete 03/07/2025.

• A thorough review of the sensory garden has taken place by Nursing, Occupational Therapy, Health & Safety and an external Garden Maintenance company with a view of enhancing the safety and experience for residents using the garden. Pathways in the garden have been power washed and general post-winter maintenance works are ongoing. Any broken equipment have been removed or replaced; the gazebo has been repaired and painted and approval has been sanctioned for the repair or replacement of the wooden posts around the raised beds. Expected Completion date 31/08/2025.
• The provider is currently sourcing natural tree screening to supplement the fencing to both enhance the environment and provide additional security to the unit. CCTV has also been approved for installation to monitor external doors to further enhance resident safety and this will be installed by 30/08/2025. These measures will further mitigate the risk of absconsion and support access for residents.
• The Health & Safety Officer has provided advice and support to the centre as regards individual risk assessment for residents having unrestricted access to the garden on such grounds as mobility, falls risk, absconsion risk. This will include consideration of the underlying psychical or psychological factors of the person's risk profile, all alternative measures trialed and outcomes. Appropriate clinical assessments are completed for each resident such as Multi Factorial Falls Risk Assessments to identify, mitigate and manage such risk.
• These individual risk assessments are currently underway. Where residents are identified as having low/limited risk they will supported with unrestricted access to the garden. Those of a higher risk will be facilitated with supervised access to the garden on request and will be encouraged to avail of same on a regular basis by the activities and care team. Completion date: 31/07/2025
• As part of the Health & Safety Officer's recommendations, the centre is sourcing

quotations for handrails for the sloped portion of the garden to further reduce the risk of falls which should reduce risk to a larger proportion of residents and support free access to the garden. Expected Completion date: 30/09/2025.
• As an interim support while awaiting the additional handrails, CCTV and tree screening, the Dayrooms are supervised and the doors are left open as weather permits. Once the above measures are in place it is intended to disable the key pad lock during day time hours.
• The activity team also encourage all residents to enjoy the garden and support same to greatest extent – for instance the evening meal was held in the sensory garden last week which received excellent feedback.

• Further training on managing behaviour that is challenging is scheduled to take place on the 14th of July. The two staff members noted in the report are both schedule to attend same. The centre now has two in-house trainers which will allow regular and iterative training in this area to be delivered. Expected completion: 14/07/2025
• For any resident displaying responsive behaviour, there are person-centered care plans in place with other proactive and reactive measures to distract and de-escalate in order to avoid recourse to any restrictive practice.
• ABC Charts are also used in the centre as a tool for analysing behaviours by systematically recording what happens before (antecedent), during (behaviour), and after (consequence) a behavioural event with the purpose of developing more targeted strategies to manage and support positive behaviour.
• The centre is committed to minimizing and eliminating any restrictive practice where possible and supporting residents with behaviours that may challenge in as safe a manner as possible. A log of any clinically indicated restrictive practice measures is kept at the centre and reviewed weekly by the nurse management team to ensure that any such measures are in the least restrictive manner and for the least amount of time possible. Complete.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A privacy roller blind has been fitted on the glass panel of the single room door, ensuring the resident's privacy in the bedroom. Complete 03/07/2025.

• The centre's activity schedule is currently under review based on the resident's individual "Key to Me" assessments, Residents survey data and residents forum meeting minutes to ensure resident specific meaningful activities are provided. Completion Date: 31/07/2025

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.	Not Compliant	Orange	30/11/2025
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	30/09/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	31/10/2025

Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/07/2025
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	30/11/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	31/08/2025
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is implemented in the	Substantially Compliant	Yellow	31/08/2025

	designated centre, as required.			
Regulation 27(c)	The registered provider shall ensure that staff receive suitable training on infection prevention and control.	Substantially Compliant	Yellow	31/08/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	03/07/2025
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	03/07/2025
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	Substantially Compliant	Yellow	31/07/2025

	followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	03/07/2025
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	03/07/2025
Regulation 6(1)	The registered provider shall, 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.	Substantially Compliant	Yellow	31/07/2025
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by	Substantially Compliant	Yellow	03/07/2025

	the medical practitioner concerned, the recommended treatment.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/07/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/09/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/07/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	03/07/2025