Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St Camillus Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Shelbourne Road, Limerick
Type of inspection:	Unannounced
Date of inspection:	10 March 2025
Centre ID:	OSV-0000640
Fieldwork ID:	MON-0046535

About the designated centre

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

The designated centre of St Camillus' Community Hospital is located on the main campus of the hospital in Limerick city. The centre is operated by the Health Service Executive (HSE) and is registered to accommodate a maximum of 16 residents. Information provided in the statement of purpose for the centre describes care for people over 18 years of age across the range of abilities from low to maximum needs in relation to advanced age, vascular and neuro-injury, dementia and physical or psychiatric chronic illness. Care planning processes are in accordance with assessments using an appropriate range of validated assessment tools and in consultation with residents. Arrangements are in place to provide residents with access to activities and there is a variety of communal day spaces provided including a large activity area on the first floor. Visiting arrangements are in place and residents are provided with information about health and safety, how to make a complaint and access to advocacy services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Monday 10 March 2025	09:55hrs to 18:00hrs	Rachel Seoighthe	Lead

What residents told us and what inspectors observed

On the day of the inspection, the inspector observed that residents were supported to enjoy a satisfactory quality of life, supported by a team of staff who were kind and responsive to their needs. Feedback from residents was that they were happy with the care they received and their life in the centre.

The inspector was met by a clinical nurse manager upon arrival to the centre. Following an introductory meeting with the management team, the inspector walked through the centre, giving an opportunity to meet with residents and observe their living environment. At this time, some residents were observed relaxing in the communal area, while others were in the process of getting ready for the day.

Located on the main campus of a hospital in Limerick city, St. Camillus Community Hospital is registered to provide care for a maximum of 16 residents. There were seven residents living in the centre on the day of inspection. Resident bedroom accommodation was provided in single and shared bedrooms, in an area known as the Shannon Unit.

There was a calm and relaxed atmosphere for residents in the centre and the inspector overheard polite conversation between residents and staff. The inspector observed that the majority of residents spent their day in the communal sitting room, located opposite the nurses' station. Other communal areas available for resident use included a dining room and a spacious activity room.

On a walk around the centre, the inspector noted that the provider had commenced the refurbishment and reconfiguration of a small number of resident bedrooms since the previous inspection. However, the inspector observed that some areas of the residents' care environment were in a poor state of repair. The inspector noted that wall paintwork, wood finishes and floor surfaces in some parts of the centre was worn, unsightly and did not enable effective cleaning. The inspector observed that some resident bedrooms were personalised with items of significance such as photographs, ornaments and soft furnishings. Call bells and televisions were provided in resident bedrooms. The corridors in the centre were long and wide and provided adequate space for walking. Handrails were available along all the corridors to maintain residents' safety and independence.

There was visible damage to the cross corridor fire door at the entrance to the activity centre, and the inspector observed that several cross corridor fire doors did not appear to close fully. The inspector also observed gaps under a number of fire doors. Both of these issues could potentially impact the containment of fire, smoke and fumes, in the event of a fire emergency in the centre.

Staff were observed assisting residents with their care needs, as well as supporting them to mobilise to different communal areas within the centre, and the inspector observed some pleasant interactions between residents and staff. The inspector

noted that the majority of residents spent their day in the communal sitting room watching television, and a small number residents chose to relax in their bedrooms.

While residents were comfortably gathered in the communal sitting room, and there was a staff presence at all times, the inspector found that there was limited opportunities for social engagement or for the residents to participate in a programme of activities in the designated centre.

Visiting was being facilitated and visitors were observed meeting with the residents during the inspection.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection, scheduled to follow up on unsolicited information received, relating to insufficient access to resident financial information. A review of record management systems and local procedures around resident finances found that this information was substantiated. Residents' rights to retain control over their finances, were restricted by local procedures which were not informed by a clear local policy. Local procedures did not align fully with the registered providers' national policy in relation to the management of resident finances.

Furthermore, the system for the management of resident personal possessions was not adequate, as the process was not clearly defined. Following this inspection, the provider was required to submit an urgent compliance plan to the office of the Chief Inspector, providing assurances that there were robust systems in place, which upheld residents' rights to retain control over their finances and valuables, and that records relating to resident finances would be held securely in the designated centre, and accessible to residents. The provider's urgent compliance plan response did not provide adequate assurance that the risk was addressed.

The inspector also followed up on actions taken by the provider to address areas of non-compliance found on an inspection of the centre in October 2024.

The provider of the centre is the Health Service Executive. A general manager of older persons services provided operational oversight for St Camillus Community Hospital, which was one of two designated centres for older persons, located on the site of a large hospital campus. The person in charge was responsible for the overall management of both designated centres. The Chief Inspector had attached a restrictive condition to the registration of the centre in June 2024, requiring the registered provider to nominate a person who would participate in the management (PPIM) of St Camillus Community Hospital, by 31 October 2024. This inspection

found that the registered provider had failed to comply with this condition of registration.

Within St Camillus Community Hospital, the person in charge was supported in their role by an assistant director of nursing (ADON) and a clinical nurse manager (CNM). A team of registered nurses, health care assistants, multi-task attendants, and maintenance personnel, made up the staffing compliment. The assistant director of nursing deputised in the absence of the person in charge. There were seven residents living in the designated centre on the day of inspection and records showed that there was a registered nurse on duty at all times, to oversee the clinical needs of the residents.

The provider did not have the resources in place to ensure the effective delivery of care, in accordance with the centre's statement of purpose. For example, the centre's statement of purpose stated that seven healthcare assistants and six multi-task attendants were required to meet the care needs of 16 residents. However, on the day of the inspection, four healthcare assistants and four multi-task attendants were employed by the registered provider. Agency staff were used to supplement the rosters on a daily basis. The person in charge had escalated this risk to the provider, and the occupancy of the centre was restricted to a maximum of 10 residents, as a mitigating measure.

While staffing levels were adequate to meet the assessed needs of residents on the day of the inspection, the supervision of staff impacted on the delivery of care to residents. For example, inadequate supervision of staff to deliver appropriate social care and support resulted in residents having inconsistent opportunities to participate in activities, in accordance with their interests and capacities. The arrangements for facilitating activities on the day of inspection were not clear. Residents were observed in a day room, watching television, or in their bedrooms, throughout the day of the inspection. While one resident had planned on attending an activity in the other designated centre, located on the same site, they were unable to do so, due to a communication issue between staff. While a staff member was seen providing a nail care activity in the sitting room in the evening time, no other activity was observed taking place throughout the day of inspection.

Records demonstrated that the provider had made arrangements to facilitate training for staff in fire safety, infection control, manual handling and safeguarding vulnerable persons.

Management oversight systems across a number of areas were not robust. The inspector found that the lines of accountability and responsibility for the management of resident finances was unclear. Responsibility for the management of resident finances was devolved among administrative staff outside of the designated centre, who reported directly to a general business manager and personnel in a centralised financial department. The person in charge did not have direct access to records relating to resident finances, or monies held on behalf of residents by the provider. Although there was a system in place for residents to access their monies when administration staff were on duty, there was no arrangement which allowed residents to access monies, or records regarding their finances, outside of

administration staff working hours. Staff were unclear on how a resident might access their monies, if they decided they wanted to purchase something on a weekend or in the evening time. The system in place did not uphold residents' fundamental rights to retain control over their finances. The person in charge had identified that the restrictions around resident finances was a significant risk, which had been escalated to the registered provider. Despite knowledge of the risk, there was no clear time-bound plan of the interventions required to address the issues identified.

Record management systems were not robust, and they did not align with the requirements of the regulations. Records relating to resident financial statements and resident financial information were not held in the designated centre, as required under Schedule 3. Records of residents individual ledgers were not available for residents to view, as the system in place did not enable this function. Records of some valuables held in the designated centre were poorly maintained.

The system in place for the management of resident personal possessions was unclear. The person in charge had initiated the development of personal property care plans for all residents and a property disclaimer was placed in each resident file. The property disclaimer stated that valuables could be deposited with the administration office for safekeeping. However, this statement did not aligned with local procedures and the inspector found that valuables were not held by administration staff. The inspector was informed that, in the event that valuables were being held for safekeeping by nursing staff, they were kept for least amount of time possible. However, the inspector observed there were a small number of personal possessions which had been held in the centre for safekeeping, for a number of years. There was no system in place to record the ownership of these items or the exact date upon which they were deposited for safekeeping.

Risk management systems were not effectively implemented and risks associated with fire safety were not acted upon in a timely manner, to ensure the safety and welfare of residents. A number of fire safety risks had been identified on the previous inspection in October 2024 and the provider had committed to addressing the issues identified. Records demonstrated that the delays in completion of fire safety works had been escalated to the registered provider by the person in charge, and while some action had been taken, the compliance plan committed to by the provider following the previous inspection had not been completed.

A record of all accidents and incidents involving residents that occurred in the centre was maintained. The majority of notifications required to be submitted to the Chief Inspector were done so in accordance with regulatory requirements. However, the person in charge did not notify the Chief Inspector of a potential safeguarding concern within the required time frames, as stipulated in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The provider had an accessible complaints procedure in place which included a review process. The complaints procedure was made available for residents and their representatives.

Regulation 15: Staffing

The number and skill mix of staff was appropriate with regard to the healthcare needs of the residents and the size and layout of the designated centre, on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The supervision of staff did not ensure the effective delivery of care to residents. For example:

- The arrangements in place to supervise the provision of activities was not consistent, which impacted on the quality of social care for residents.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider did not maintain records as required under Schedule 3 of the regulations :

- The provider did not ensure that all records relating to resident finances were kept in the designated centre. Records relating to residents individual ledgers and up-to-date statements of accounts were not made available for inspection by the Chief Inspector on 10 March 2025.
- Record of valuables deposited by some residents for safekeeping were not made available for inspection by the Chief Inspector on 10 March 2025.

An urgent compliance plan was requested, to provide assurances that there were effective record management systems in place, to enable residents to access up-to-date information in relation to their finances, and that such records would be held securely in the designated centre, and accessible to residents at all times. The providers response did not provide assurance adequate assurance that the risk was addressed.

Judgment: Not compliant

Regulation 22: Insurance

The provider had an up-to-date insurance contract in place against injury to residents, and loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

The management structure was not clearly defined. Responsibility for the management of resident finances and possessions was devolved to personnel who did not report directly to the person in charge. Management supervision systems failed to recognise that local procedures around resident finances created a barrier to residents financial autonomy, which was not in keeping with a rights' based approach to resident care.

The registered provider was in breach of a condition of registration following failure to appoint a person who would participate in the management (PPIM) of St Camillus Community Hospital, by 31 October 2024.

The registered provider did not ensure that the centre had the resources in place to ensure the effective delivery of care in accordance with the centre's statement of purpose. The provider relied on the availability of agency staff to meet the staffing requirements of the centre on a daily basis.

The management systems in place did not provide full assurance that the service was safe and consistent. This was evidenced by:

- Inadequate oversight of residents' rights as evidenced by restricted access to resident finances, and a lack of opportunities for social engagement, as observed on the day of the inspection.
- The registered provider had not ensured that record management systems were effectively implemented, records relating to resident finances were only accessible during administration staff working hours, and not all records set out in Schedule 3 were kept in the designated centre.
- The system for storing residents personal valuables was unclear and not known to staff who were responsible.
- The registered provider had not ensured that some risk management systems were effectively implemented. The inspector found that risks in relation to fire safety were not identified and effectively mitigated. This was evidenced by findings as detailed under Regulation 28.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider did not notify the Chief Inspector of a potential safeguarding concern within the required timeframe, as stipulated in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints records found that complaints and concerns were responded to and managed in line with the requirements of Regulation 34.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider was delivering a satisfactory standard of clinical care to residents, in line with their assessed needs. Residents who could express a view reported satisfaction with the quality of the service provided. However, the arrangements in place for residents to retain control over their finances were not aligned with regulations. The provider was required to submit an urgent compliance plan to the office of the Chief Inspector following this inspection. Furthermore healthcare, premises and fire precautions did not meet the requirements of the regulations.

Residents had opportunities to provide feedback to the management team regarding the quality of the service. Residents had access to local and national newspapers, television and radio. There were arrangements in place to ensure that residents were informed of, and were facilitated to access advocacy services. However, this inspection found that residents' civil rights were not always promoted in the centre. Resident rights to access information in relation to their finances was restricted and residents' rights to access to their monies were not upheld at all times. Furthermore,

while there were some opportunities for residents to participate in activities in accordance with their interest and capabilities, these were not consistently provided.

The provider had taken some action with regard to the maintenance of the premises since the previous inspection, and works to refurbish the care environment had commenced. While the centre generally provided a homely environment for residents, the inspector observed that surfaces and finishes including paintwork, wood finishes and in a number of areas were worn and unsightly, and did not facilitate effective cleaning. This is detailed further under Regulation 17, Premises.

The designated centre had a fire safety system in place, including fire-fighting equipment and a fire detection and alarm system. However, the maintenance of some fire doors did not ensure that appropriate systems of fire and smoke containment were in place. This may impact the effectiveness of the fire doors to contain smoke and fire in the event of a fire emergency. This is detailed further under Regulation 28, Fire precautions.

A review of residents' care records confirmed that they had regular access to medical officers. Clinical risks such as infection and weight loss or gain were regularly monitored by the nursing team. There were no wounds in the centre at the time of inspection. There was a system in place to refer residents to allied health services such as occupational therapy, speech and language therapy and dietetics. However, the inspector found that access to physiotherapy services was insufficient to meet the needs of some residents. This is detailed further under Regulation 6, Health care.

The centre had a paper-based resident care record system. Pre-admission assessments were undertaken by the person in charge to ensure that the centre could provide appropriate care and services to the resident upon admission. A range of validated nursing tools were in use to identify residents' care needs. The inspector viewed a sample of files of residents with a range of needs and found that resident individual assessments were completed in a timely manner and care planning documentation reviewed was person-centred. Records confirmed that residents and or their families were consulted about the development of individualised care plans.

Visitors were observed attending the centre throughout the day of the inspection. The inspector saw that residents could receive visitors in their bedrooms or in a number of communal rooms.

Regulation 28: Fire precautions

The provider did not ensure that adequate precautions were in place to protect residents and others from the risk of fire and that the centre was in compliance with Regulation 28, Fire precautions as follows:

- There were gaps between the floor and the bottom of the cross corridor leading to the activity centre. This door was damaged and did not form an effective seal when closed. This may impact on the effectiveness of the fire doors to contain fire, smoke or fumes.
- Several cross corridor fire doors did not form an effective seal when closed.

These are repeated findings.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care planning documentation was available for each resident in the centre. The care plans reviewed were person-centered and guided care. Comprehensive assessments were completed and informed the care plans.

Judgment: Compliant

Regulation 6: Health care

Residents did not have access to physiotherapy services in a timely manner. For example, two residents with assessed mobility needs were referred to physiotherapy services in January 2025, however, they had not been assessed by a physiotherapist at the time of inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider did not ensure that residents could exercise their civil rights. For example:

- Residents' rights to access information in relation to their finances were not upheld. Records of individual comfort account ledgers were not available and statements of resident accounts and financial information were not held in designated the centre.
- Residents' rights to access to their monies were not upheld at all times. There were no clear arrangements in place to facilitate requests for monies, if made outside the working hours of the administration staff.

An urgent compliance plan was requested, to provide assurances that there were systems in place, to enable residents to retain control over their finances.

The registered provider did not ensure that there were facilities for residents to participate in activities, in accordance with their interests and capacities.

Judgment: Not compliant

Regulation 17: Premises

The inspector found that the premises was not fully in compliance with Schedule 6 of the regulations. This was evidenced by:

- Bins, including clinical waste bins, were rusted and damaged and could not be cleaned effectively. This is a repeated finding.
- The wall surface in one resident's shared shower room was damaged could not be cleaned effectively.
- There was inadequate storage for some residents' assistive equipment, and the inspector observed the storage of shower chairs in shared resident bathrooms.
- Paintwork on some wall surfaces and skirting boards was chipped and scuffed, and some floor surfaces were worn.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Not compliant
Regulation 17: Premises	Substantially compliant

Compliance Plan for St Camillus Community Hospital OSV-0000640

Inspection ID: MON-0046535

Date of inspection: 10/03/2025

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 provision of ongoing and individualised activities to the residents in Shannon unit has been reviewed in conjunction with the unit manager, activity staff and the residents. Access to activity supplies has been improved to ensure that our care team incorporate appropriate activities into the day to day care of our residents. This is monitored and reviewed by the nurse in charge daily.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Actions completed: Records relevant to the residents' finances are now located securely in the designated centre. There is an individual folder available for each resident. These are maintained with up to date statements of accounts, details of monies spent and itemized and are available for inspection. A care plan specific to the resident's individual financial requirements has been developed in conjunction with the resident and is available within the resident record. The Patient Private Property Form has been amended and now only reflects monies held where they have been handed in for safe keeping. Records of same are maintained. Valuables can be held for safe keeping for short periods in exceptional circumstances and this is managed by the clinical staff on the Unit within the designated centre	

The system in place for filing of records pertaining to the designated centre has been revised to enable efficient accessibility to requested records.

Actions to be completed:
The actions completed are in operation. Local policies and procedures and guidance documents review and drafting has commenced in line with the changes to practice and to reflect these revised local management arrangements.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Actions completed:
Management structure and systems for residents' finances: A full overview of the management and record of residents finances has been completed under the following categories:

1. Role and responsibility in relation to residents' property and monies within the designated centre have been clearly defined within the management structure. This has involved communication and education of staff in relation to the management of residents' monies and property.

2. Oversight of management of records to include the storage of residents finances files within the designated centre and the streamlining of financial files into individual financial files. There is a folder for each resident to detail residents' monies and this is maintained within the designated centre. A meeting schedule is in place for the PIC to review each resident's records and to ensure that they have access to same.

3. Record management systems: The system in place for filing of records pertaining to the designated centre has been revised to enable efficient accessibility to requested records.

4. Access to their own monies, Mon – Sunday: a process has been put in place to ensure access to residents' own monies at any time of the day for each resident. All staff are aware of this process and will facilitate access for the residents at their request.

5. All changes in practice have been communicated, verbally and in writing, to all relevant staff.

Recruitment campaigns have been completed and recruitment of nursing staff is being progressed with dates of starting commencing on 5th May 2025. This will address over reliance on agency staff within the Unit.

PPIM: The PPIM for the designated centre has been identified and documentation to support the application and the application form for PPIM has been submitted to the regulatory authority on 25th April 2025.

Fire safety: A full assessment of the fire doors has been carried out by an external company and the report has been communicated to the relevant department for remedial action.

Actions to be completed:
The actions in relation to record management systems have been completed and are in operation. Local policies and procedures and guidance review and drafting has commenced in line with the changes to practice and to reflect these revised local management arrangements.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Actions completed:
All required notifications have been completed and submitted to HIQA in line with regulatory requirements

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Actions completed:
Remedial actions have been taken and replacement of intumescent strips have been carried out where required.
A full assessment of the fire doors has been completed by an external company and the report has been communicated to the relevant department for remedial action.

Fire training and fire evacuation drills continue to provide assurance that residents can be evacuated safely and in a timely manner.

Fire safety equipment and systems are regularly checked and serviced.

Actions to be completed:
In line with public procurement regulations, the registered provider is currently in the

process of procuring an architect lead team to put a tender package together for fire door works. This package will have to go to tender and be awarded to a contractor before works can commence. It is anticipated that the timeframe for works to be completed, taking into account the public procurement process, is the end of October 2025.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All residents referred for physiotherapy services have received this service. Access to physiotherapy for residents will be provided in a time appropriate manner.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Actions completed:
Records relevant to the residents' finances are located in the designated centre.
There is an individual folder available for each resident. These are maintained with up to date statements of accounts, details of monies spent and itemized and are available for inspection.

A care plan specific to the resident's individual financial requirements has been developed in conjunction with the resident and is available within the resident record.

Access to information about monies: Within the designated centre, there is an individual folder detailing monies available to each resident and spent, itemized, updated and presented to each resident on a monthly basis or as required for their own information. This process will be guided by the care plan in place for each resident.

Access to their own monies, Mon – Sunday: a process has been put in place to ensure access to residents' own monies at any time of the day for each resident. All staff are aware of this process and will facilitate access for the residents at their request.

Actions to be completed:
An information leaflet on how residents' monies are been managed by the service will be developed in conjunction with the residents. This will highlight how the service will support the rights of the residents their accessing their monies.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Actions completed :
Bins in the Unit have been reviewed and replaced where they were seen to be rusted.
The wall surface in one resident's shared shower room has been repaired.
Assisted equipment is being stored appropriately.
Areas requiring painting have been completed. There is a system in place to report required areas for maintenance/painting on and ongoing basis.

Actions to be completed:
Worn floor surfaces are scheduled for repair.
The Unit will undergo a further uplift with the installation of additional flat screen TVs, and new wardrobes for personal possessions.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/03/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2025
Regulation 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.	Not Compliant	Red	20/03/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Not Compliant	Red	20/03/2025

	be safe and accessible.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/05/2025
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	25/04/2025
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 effectively monitored.	Not Compliant	Red	20/03/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2025
Regulation 31(1)	Where an incident set out in	Not Compliant	Orange	30/03/2025

	paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	20/03/2025
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	28/03/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Red	20/03/2025