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:	Abbey Haven Care Centre & Nursing Home
Name of provider:	Abbey Haven Care Centre & Nursing Home Limited
Address of centre:	Carrick Road, Boyle, Roscommon
Type of inspection:	Unannounced
Date of inspection:	20 February 2025
Centre ID:	OSV-0000738
Fieldwork ID:	MON-0044875

About the designated centre

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

Abbey Haven Care Centre and Nursing Home is a purpose-built facility which can accommodate a maximum of 63 residents. It is a mixed gender facility catering for dependent persons aged 18 years and over and it provides care to people who require long-term residential care or who require short term respite, convalescence, dementia or palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. In their statement of purpose, the provider states that they are committed to enhancing the quality of life of all residents by providing high-quality, resident-focused care delivered by appropriately skilled professionals.

This centre is situated on the outskirts of the town of Boyle and is a short drive off the N4 Dublin to Sligo link road. It is a large modern building constructed over one floor. Bedroom accommodation consists of single and twin rooms, all with full en-suite facilities. A variety of communal accommodation is available and includes several sitting rooms, dining areas, a prayer room and visitors' room. The centre has a large safe garden area that can be accessed from several points and has features such as a fountain and raised flower beds that make it interesting for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	62

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 20 February 2025	09:00hrs to 19:00hrs	Celine Neary	Lead
Thursday 20 February 2025	09:00hrs to 19:00hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

Although residents did provide positive feedback about the care and support they received, inspectors were not assured that all residents, especially residents living with cognitive impairment, were afforded the same level or quality of care. This was evidenced by the inspectors' observations and a review of documentation in the centre on the day of the inspection. The inspectors found that significant actions were required to improve the care and welfare of residents. These are discussed under the relevant regulations and under the themes of Quality and Safety and Capacity and Capability in this report.

Following an introductory meeting with the person in charge and a senior nurse, the inspectors commenced a walk around of the designated centre, where they had the opportunity to meet with several staff and residents. Inspectors observed that several staff members were wearing face masks and were informed by staff that this was a precautionary measure, even though there were no confirmed cases of infection in the centre on the day. Staff told the inspectors that they were wearing masks for safety reasons, as there was a virus in the centre in January. Management told the inspectors that not many residents were attending the day rooms or dining room as they were socially distancing residents as a further precautionary measure. This was not in line with the current national infection prevention and control guidelines.

Inspectors arrived early at the centre and observed that the breakfast experience for the residents in the centre was not fully supportive of their rights. All residents were served breakfast in bed, and residents were not encouraged or offered a choice to use their dining room. This was brought to the attention of the management personnel on the day of the inspection, who confirmed that the residents had not been offered the breakfast experience in the dining room since the COVID-19 pandemic due to the risk of cross-contamination.

The inspectors observed staff were working hard to provide care and support to residents, many of which had high dependency needs. Management told the inspectors that more than 65% of their residents had cognitive impairment and required additional care and support with their activities of daily living.

During the walk around of the centre inspectors observed that several residents did not have access to emergency call bell facilities in their bedrooms, if they required help or support. On several occasions during the walk around, the inspectors observed that, the person in charge had to seek staff to assist and attend to residents in need of support and care.

One resident told the inspectors that they "had pain and they felt sore". The person in charge requested a nurse to attend to this resident and subsequently pain relief medication was administered. Inspectors heard another resident verbally calling for a nurse on several occasions during the walk around. When the inspectors reached

this residents bedroom they observed that this resident did not have a call-bell within reach. The person in charge went to find a member of staff to assist and support this resident. Staff were busy attending to residents in their bedrooms and not all call bells were answered or responded to in a timely manner.

Inspectors found that there was an insufficient number of staff available to provide adequate supervision and support for residents on the day of inspection. Care staff were present in each unit, but were busy attending to their assigned duties. Inspectors observed periods where residents had to wait up to six minutes for staff to come to them to attend to their needs. The inspectors observed one resident trying to get out of their bed but was restricted because there were bed rails in place. The inspector brought this to the attention of a staff member who then attended to the resident.

Furthermore, inspectors observed that two care staff were deployed from their roles of providing personal care and support to residents, to provide tea and drinks to residents. The inspectors saw that several residents were still in bed at 11:30 in the morning and could not be assured that they had been offered or had received care and support to start their day. For instance, the inspectors saw a number of residents who required assistance and were at risk of falling or trying to seek assistance from staff. This was brought to the attention of the person in charge who had to seek staff to assist these residents. In addition, the care staff team were short of staff on the day of the inspection, which negatively impacted on the clinical care and support for residents.

The centre was visibly unclean in several areas, and inspectors observed several items of equipment, such as wheelchairs, commodes, urinals, and a handheld machine for crushing medications that were visibly unclean.

Staff members were seen wearing Personal Protective Equipment (PPE) incorrectly; for instance, several staff wore their face masks under their noses, and some did not sanitise their hands before providing personal care and in between residents.

Additionally, there were insufficient hand hygiene facilities available to promote effective hand hygiene practices.

While there was an activity programme in place, the inspectors observed that there was a lack of choice of meaningful activities available, and several residents were not actively involved in activities. By way of an example, inspectors noted that there were only 19 residents out of 62 residents actively engaged in the activities provided at 11.35 am. At the later stage, around 14.30 pm, residents were seen watching television, and inspectors noted that even smaller number of residents were engaged in the activities in the afternoon.

Throughout the inspection, several residents were seen sleeping in their chairs or walking without purpose, around the centre. Furthermore, staff told inspectors that they had not been providing one-to-one activities for residents since a virus outbreak in the centre in January 2025

Easy access to the enclosed courtyard garden was not available for all residents. Inspectors observed that residents had to seek assistance from staff to gain access to their garden area as only one door was open at the reception. The other seven doors were closed, and the staff was required to open them as it was difficult to open the locked doors without assistance. In order to open the doors to the courtyard, it required to press and hold a button at the same time, while pushing the door open. This did not facilitate easy access for residents, especially residents with cognitive and mobility impairment, to their courtyard garden area.

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

Capacity and capability

This inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and to follow up on concerns that had been received in relation to the care and welfare of residents living in the designated centre. This inspection validated the concerns in relation to the care and welfare of residents who required additional support with their nutrition and skin integrity needs. It also substantiated concerns received by the Chief Inspectors office, regarding the management of infection, prevention and control and the cleanliness of the centre. Significant improvements were required in relation to several regulations, as discussed in this report.

The registered provider for this designated centre is Abbey Haven Care Centre and Nursing Home Limited. The inspection was facilitated by the person in charge and a director of the limited company. There was a clearly defined management structure in place that identified clear lines of authority and accountability.

The provider had nominated a senior nurse for the role of IPC (Infection prevention and control) link practitioner.This nurse had completed the national IPC link practitioner course. However, inspectors found that the current governance and managerial oversight of the designated centre was not effective, and did not ensure that care and services were provided.

There were inadequate staff resources in the centre to ensure the effective delivery of care to residents, in line with the centres statement of purpose. On the day of this inspection there were inappropriate levels of staff available, based on the assessed needs of residents. Furthermore, the provider had failed to adequately resource housekeeping, laundry and catering staff, to provide a safe and effective service.

While there were systems in place to monitor the quality of the services provided, inspectors were not assured that these systems were effective. The audit system in place included medication management, falls and infection control. However, the

monitoring and oversight processes that were in place had not identified a number of areas for improvement found on this inspection and there were not always action plans associated with findings. This is further detailed under Regulation 23.

The annual review for 2024 was nearing completion at the time of the inspection. The review included feedback from residents. The review set out the quality improvements the provider intended to make for the coming year. This included feedback from residents meetings held throughout the year and 11 resident/family satisfaction surveys.

Inspector's also found that the provider did not always follow their own polices and procedures to maintain standards in practice. This is discussed further under Regulation 27: Infection control.

In addition, the risk management processes were not effective in ensuring that risks were identified and mitigated, particularly in relation to the management of falls and infection in this designated centre.

Training in the centre was not well-monitored and the supervision and deployment of staff required significant review. Records showed that not all staff had attended training appropriate for their roles and responsibilities.

A comprehensive and accurate directory of residents was kept in the centre and was available for inspectors to review. It contained all the required information.

A number of notifications had not been submitted to the Chief Inspectors office. This is a repeat finding from previous inspections.

Inspectors reviewed the complaints policy, procedures and complaints register. The provider kept a record of complaints received. Complaints were investigated and the outcome was communicated to complainants. An appeal process was available if complainants were dissatisfied with the outcome of the investigation of their complaint.

Regulation 15: Staffing

Inspectors were not assured that there was a sufficient number of appropriately skilled staff to meet the assessed needs of residents given the size and layout of the designated centre. For example:

- Inspectors found that on the day of the inspection, the deployment of available staff did not ensure that there was a sufficient number of staff available to meet the needs of residents. As a consequence residents' clinical and social care needs were not adequately met.
- There was an insufficient number of staff to ensure residents at risk of falling were supervised and that residents displaying responsive behaviours were provided with meaningful interactions.

- There was an insufficient number of staff to provide a timely response to residents' ringing their call bells for assistance. As a result residents were left unattended or came to seek assistance from staff at the nurses station. Inspectors heard one resident calling out for a nurse and had to request assistance for this resident on two occasions. Another two residents required assistance and support during the walk around and inspectors observed residents coming to the nurses station or reception seeking help and support from staff during the day. Furthermore, it was difficult to locate staff to provide assistance for these residents, as they were busy attending to other residents in their bedrooms.
- The centre did not have adequate numbers of cleaning staff available to ensure the environment and equipment was appropriately cleaned and to ensure residents were protected from the risk of infection. For example; the housekeeping staff were responsible for laundry alongside their housekeeping duties.
- There was insufficient staff provided to support the chef in the kitchen and adjoining area's. As a result, the dining room floor and fridge in the kitchenette area were visibly dirty.
- There was insufficient staff available to provide activities for 63 residents on the day of inspection. One activity coordinator was observed providing some activities in the activity day room for 19 residents. The inspectors observed that activity sessions were sometimes interrupted as the activity coordinator was called upon to assist with residents care. Furthermore, staff confirmed that no one to one activities had taken place for residents that chose to stay in their rooms, since January.
- A review of the rosters revealed significant levels of sick leave during January and February 2025. In January, a member of the healthcare staff was deployed to work as a kitchen porter because there was no kitchen porter available to cover planned leave. Additionally, the vacant staff positions were not filled, which impacted the level of care and support provided to residents. On the day of the inspection, three staff members were on leave, and no replacements were arranged for them.

Judgment: Not compliant

Regulation 16: Training and staff development

Although most training records were maintained to record and ensure staff were up to date with mandatory training, seven registered nurses were awaiting cardio pulmonary resuscitation (CPR) training, eight were due training on the use of personal protective equipment (PPE), and four on hand hygiene. Inspectors identified, through talking with staff and observations of staff practices, that further training and supervision was required to ensure staff are knowledgeable and competent in the management of urinary catheters, recognising early signs of infection, antimicrobial stewardship and the appropriate times to perform hand

hygiene.

Staff did not have access to appropriate training in relation to nutritional care of residents at risk of weight loss, wound care, falls management and caring for residents with responsive behaviours. As a result, inspectors found that staff did not identify, monitor or address residents care needs in a timely manner.

Staff supervision was not robust and required improvement. For example, staff were not consistently implementing the provider's own policies and procedures in order to ensure care and services were consistently provided to the required standards. This was evident in the following areas; cleaning procedures, storage of residents' equipment, the management of signs and symptoms of infections, wound care, nutritional support and assessment and care planning practices. These findings are set out under the relevant regulations.

Judgment: Not compliant

Regulation 19: Directory of residents

An updated directory of residents was maintained in the centre. This included all of the information as set out in Schedule 3 of the regulations, including the dates of admission and discharge, and contact details for the nominated resident's representative.

Judgment: Compliant

Regulation 23: Governance and management

The allocated resources in respect of the staffing levels were not in line with the provider's statement of purpose. As a consequence, the measures in place to mitigate risks were not effective, which negatively affected the quality and safety of care provided to residents. For example:

- The allocation of staff resources required review as inspectors observed instances where residents were not afforded help when required and were left unsupervised. In addition, a member of the health care team was redeployed to perform kitchen duties. There was no staff available to cover duties in the laundry, and the housekeeping staff were also redeployed to cover this vacancy.
- There was only one activity staff working during the inspection, and there was a lack of evidence that there were any staff members allocated to provide activities for residents who did not wish to take part in the group activities or were not able to participate. Feedback from residents and

observations of inspectors confirmed that there were no one-to-one activities carried out.

The governance and management systems in place required further strengthening to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by the following:

- There was inadequate oversight of key areas, such as staffing, training, infection prevention and control, care planning and health care. While some auditing was carried out, it did not serve as a tool to improve quality improvement as there were no associated improvements plans and actions to address the areas identified for improvement identified in the audits. Furthermore, there was no analysis, trending or review of the key information collected from these audits to mitigate or improve the service provided.
- The oversight of staff training and the processes in place to ensure that staff received training was not adequate and did not ensure that when staff training was due, this was provided in line with the provider's policy. In addition, staff supervision and staff practices require a review to ensure that the care delivery is safe and in line with best-evidenced practices.
- The oversight of the mandatory reportable incidents was not notified to the Chief Inspector of Social Services in accordance with the requirements of Schedule 4 of the regulations.
- The oversight by management of assessment and care planning processes did not ensure that procedures were implemented in line with the provider's own policy and procedures and the requirements of the regulations. As a result, the relevant information regarding each resident's needs and care interventions were not available to or implemented by staff. These findings are discussed further under Regulation 5.
- The oversight of appropriate and timely referrals and reviews by health care professionals was not robust and as a result residents did not receive specialist care and advice as required. Delayed access to some health care services were not seen as a priority to be addressed. This is discussed further under Regulation 6.
- The management of risk in the centre was not adequate as the risk assessments regarding the management of falls, infections and the occurrence of unexplained bruising had not been uploaded to the centre's risk register.
- Multiple risks found during inspection had not been identified by management, and there was no learning from serious incidents or injuries to residents to mitigate or reduce the risk of re-occurrence. For example: The registered provider had not ensured that the arrangements for the identification, recording, investigation and learning from serious incidents, complaints or adverse events involving residents had taken place. This was evident from a review of 68 falls which had taken place within the centre in the last six months, which did not address or put any actions in place to reduce or mitigate the risks.

Infection prevention control (IPC) and antimicrobial stewardship governance arrangements did not ensure the sustainability of safe and effective IPC.This was

evidenced by:

- The inspectors were not assured that potential outbreaks of infection were identified, in a timely and effective manner. In one week, seven residents developed respiratory tract infections, yet there was no indication that an outbreak was considered. On the day of the inspection the centre had no viral swabs to test for influenza or other viruses aside from COVID-19. Additionally, vaccination uptake among residents was low, with 33 residents having declined the COVID-19 booster. There was limited evidence available to show that information about vaccination was provided to residents to support their informed decision-making. Inspectors could not be assured that these residents were consulted and had made an informed decision to decline their vaccination boosters.
- There were insufficient systems in place to ensure that the environment and resident equipment were cleaned in accordance with best practice guidance. The non-compliance observed during the inspection showed that all equipment, particularly frequently used equipment, was not being adequately cleaned. These management systems in place did not ensure that the cleaning procedures in the centre were completed to the recommended standards to protect residents from infection and were not in line with best practice guidelines.This is further detailed under Regulation 27: Infection control.
- The inspectors were not assured that the centre complied with best practice requirements for controls, procedures and management of Legionella bacteria in the water supply. For example, no flushing records were maintained of taps and showers in vacant rooms. No testing of the water had been undertaken.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all incidents required to be notified to the Chief Inspector were notified. During the inspection, the inspectors identified that two notifiable incidents had occurred; however, the office of the Chief Inspector had not received the appropriate notification.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy in place that was reflective of the regulatory

requirements.

Judgment: Compliant

Quality and safety

This inspection found that the current arrangements for the provision and oversight of nursing care for residents did not ensure that all residents were provided with a high standard of evidence based nursing care. Further actions by the provider were necessary to ensure that the quality and safety of care being delivered to residents was consistently and effectively managed, to ensure the best possible outcomes for residents.

From the review of residents' care records, the inspectors found that actions were required to ensure that each resident's health and social care needs were identified and that the care interventions they needed were clearly described. The inspectors reviewed a sample of residents' care documentation and found that the information required to inform effective care interventions was not always in place. Furthermore, nutritional and wound care records were not consistently maintained or documented.

Residents had access to a range of healthcare supports which included General Practitioners (GP) who regularly visited residents in the centre. A review of care plan documentation showed that residents were not always referred to or seen by health care professionals in a timely manner, or had specific treatment recommendations implemented.

Inspectors found that staff did not consistently provide appropriate support and care for those residents who may display responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). As a result some residents' behaviours were not appropriately managed by staff and were effectively de-escalated. Behavioural support care plans reviewed did not contain sufficient detail to guide staff on the interventions required to minimise responsive behaviours. In addition, staff practices in relation to restrictions on residents' access in their lived environment were not in line with the national restraint policy.

The inspectors could not be assured that end-of-life care was provided in line with residents preferences as there were no end-of-life care plans in place for some residents.

The centre was well-designed but the maintenance and general up-keep of some area's required attention and refurbishment, such as the furniture in the reception area.

The inspectors observed residents being supported at mealtimes in a respectful

manner. The meals were prepared on-site and were nicely presented and looked appetising. Residents said that they enjoyed their meals and the snacks that were offered throughout the day. However, greater monitoring of residents' nutritional status and their intake of food and drinks, was required to ensure better outcomes for residents at risk of weight loss or malnutrition.

Behavioural support care plans reviewed did not contain sufficient detail to guide staff on the interventions required to minimise responsive behaviours.

A number of practices were identified that had the potential to impact the effectiveness of environmental hygiene within the centre. For example, not all areas used by residents, such as the dining room and the oratory, were cleaned to an appropriate standard. In addition, some of the decontamination practices required review.

A range of issues were identified in the centre, in relation to infection prevention and control. For example policies and procedures for IPC were not up to date with new national guidance to guide staff, for example, the centres own policy stated all admissions were tested for COVID-19. The pre-admission assessment of new residents coming to live in the centre had no section to capture a residents infectious status. The use of PPE was not in line with the current national guidelines. On the day of the inspection a large proportion of staff were wearing face masks. Staff informed the inspectors that the reason for the mask was to give themselves protection as some residents had symptoms like coughing and sneezing and that there had been a recent virus outbreak in the centre. There was no clear identification of a residents infectious status either on the nursing handover sheet or as a discreet symbol on the door. This is further discussed under Regulation 27: Infection control.

Regulation 13: End of life

A review of care documentation showed that a resident approaching the end-of-life was not afforded appropriate care and comfort. This resident did not have end-of-life care wishes and preferences in place to guide staff in their care and to ensure that their emotional, psychological, and religious needs were met in a dignified manner and in line with the resident's wishes. As a result, this resident was transferred to the hospital and end-of-life care was delivered in a hospital.

Judgment: Not compliant

Regulation 17: Premises

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas required maintenance and repair to be fully

compliant with Schedule 6 requirements, for example:

- Couches in the reception area were visibly torn and required repair.
- Eight residents did not have emergency call-bell facilities in their bedrooms. As a result, they could not call for assistance or help if required.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Inspectors could not be assured that the dietary needs of residents were met, based on their nutritional assessments in accordance with their individual care plans. For instance:

- From the residents' records reviewed, six residents' care plans for nutrition did not accurately reflect the needs of the residents when they lost weight unintentionally, and their Malnutrition Universal Screening Tool (MUST) assessment scored high risk of malnutrition. There was no evidence available that correct interventions were in place. In addition, dietary intake observations were not completed, and the residents had not been re-reviewed by a dietitian, despite continued weight loss.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures consistent with the *National Standards for Infection Prevention and Control in Community Services* (2018) published by the Authority, were implemented. For example;

- On the day of the inspection a large proportion of staff were wearing face masks. Staff informed the inspectors that the reason for the mask wearing was to give themselves protection as some residents had symptoms like coughing and sneezing. PPE was not being used effectively, for example, some staff were wearing face masks below their noses and bringing dirty linen to the linen skip with no apron. Not adhering to appropriate standard precautions poses a risk to staff and residents of infection spread.
- More than seven residents displaying signs and symptoms of a respiratory virus during in January 2025, who were treated with antibiotic therapy, did not have viral swab testing completed to confirm or diagnose their infection.
- A resident with no symptoms of infection was attending the acute hospital for appointments a few times a week and was cared for in isolation under droplet precautions. These precautions were not appropriate and were overly

restrictive, as this resident did not have an infection.

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

- Hand hygiene facilities were not sufficiently in place for clinical staff to wash their hands if visibly soiled. This could lead to infection spread. For example:
    - The sinks used by staff to wash their hands in resident areas were dual purpose for both residents and staff to use.
    - Alcohol gel dispensers were not in place at the point of care for each resident. In one area, there was one dispenser between seven residents. The inspectors observed that some staff were not sanitising their hands between residents.
    - The alcohol gel on the drug trolleys had an expiry date of 2022.
- Resident equipment was not consistently cleaned after use to prevent infection spread to other residents. For example:
    - A wheelchair in a store room was heavily stained and a commode in the sluice room was visibly dirty.
    - The urinals used to empty catheter bags were visibly soiled; this meant that staff were not using the bedpan washer for cleaning. One resident had the overnight catheter bag left in the bathroom without a cover and staff reported that they reuse the same bag every night.This practice increased the risk of catheter-associated infections.
    - A hand held machine to crush tablets was heavily stained and dirty.
- The kitchenette and dining room fridge, and floor area were not clean. For example, the floor had visible debris from the previous days use and inside the fridge had spillages and staining.
- The storage room that was used to store chemicals had no signage on the front to alert to a hazard and had a used toilet brush soaking under the shelf.
- There was a continued reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection. This was contrary to national guidelines which advise that inappropriate use of dipstick testing can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance. Three residents were prescribed antibiotics based on a urine dipstick result.
- The management of sharps was not in line with best practice guidelines. For example; the provider had not substituted traditional needles with safety engineered sharps devices to minimise the risk of a needle stick injury. The one sharps box in use had the temporary closure open and was not signed or dated.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While some residents' individual needs were met in line with their established care

plans, the inspectors found that the standards of care provided to some residents, at the time of inspection did not ensure their assessed nutrition, hydration, healthcare and wound care needs were met. For example;

- residents' nutrition and hydration care plans were not implemented, specifically, the weight loss was not being appropriately tracked and monitored to identify a significant weight loss. Furthermore, accurate records of residents dietary intake was not recorded. Therefore, this could not guide care delivery and ensure that professional expertise was requested.
- one resident did not have any wound care dressings performed since their return from hospital, even though the dressing was visibly stained.
- one resident did not have a responsive behaviour or social activities care plan in place.
- nutritional care plans for residents with a recent history of weight loss and receiving nutritional supplementation did not include consistent records of their dietary or fluid intake.
- although there was evidence that residents' care plans were regularly updated by changing a date in the electronic system, there was no information available providing assurances that these reviews were completed in consultation with residents or their representatives, as appropriate.

Judgment: Not compliant

Regulation 6: Health care

The health care needs of residents were not provided appropriately, including a high standard of evidence-based nursing care for residents. This was evidenced by:

- Assurances were not available that the health care needs of residents with nutritional support needs were met. Although residents' weights were regularly assessed and documented, appropriate referrals were not made to dietitians when required. Furthermore, re-referrals for a review by dietitians were not made when residents continued to lose weight.
- One resident that had been assessed by an occupational therapist in December 2024 did not have the recommended treatment implemented and as a result their skin integrity had been compromised.
- One resident with a wound had not been referred to a tissue viability nurse specialist, and as a result, did not receive adequate care of their wound.
- Inspectors could not be assured that residents had access to physiotherapy in line with their assessed needs as one resident who had returned from the hospital, and was confined to bed following a surgical procedure had not been seen or assessed by a physiotherapist in more than nine days. As a result, this resident was not supported to rehabilitate or improve with their mobility care needs.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The inspectors found that some residents' experiencing responsive behaviours were not appropriately supported by staff and the documentation of the responsive behaviours experienced by residents and their care plans, were incomplete. This meant that this information was not available and effectively utilised to comprehensively inform residents' individual care and support needs.

The restrictive practices in place in the centre did not reflect best practice guidance and did not ensure that restraints were used in the least restrictive manner and for the minimum amount of time required. For example;

- Residents' access to their outdoor gardens was dependent on staff, as it was difficult to open the doors to the courtyard garden.
- Two residents with responsive behaviours were observed wandering around the centre without purpose or meaningful interactions with staff. Furthermore, these residents were not offered the opportunity to participate in activities, which might have provided a beneficial and meaningful distraction to their behaviour.
- Inspectors observed that two residents living in this centre had put signs on their doors to deter or prevent residents that displayed signs of responsive behaviours, from entering their bedrooms, uninvited.
- A number of staff had not attended training in the management of responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Judgment: Not compliant

Regulation 9: Residents' rights

Residents’ right to exercise choice in how and where they spent their day was not respected. Resident's daily routines were largely determined by staff working in the centre and did not reflect the individual preferences of residents and did not reflect flexible routines as determined by individual residents on a daily basis.

Residents' right to make individual choices were also not respected. For example; residents' choice to go outside was not supported as access to their courtyard garden was restricted. Furthermore, all residents were served their breakfast on trays in their bedrooms and were not afforded the choice to have their breakfast in the dining room if they preferred.

Residents were not provided with adequate opportunities to engage in meaningful social activities that met their interests and capacities.

Emergency call-bells were not available or accessible in several of the residents bedrooms. The inspectors observed that several residents in their rooms on the morning of the inspection, did not have a call-bell or could reach their call-bells, which posed a risk that when a resident required help, they would not be able to seek assistance.

Four residents in the activity room were sitting in their chairs with the hoist sling still in place. This practice is efficient for staff but does not promote comfort or dignity of each resident.

The inspectors found that the layout and limited space available within the bed space of residents in twin bedrooms could not ensure that their privacy was assured during transfer into and out of bed and during personal care activities. In some cases, residents would have had to enter another resident's bed space to access the en-suite facilities. Residents who shared twin rooms could not undertake personal activities in private due to the existing layout of these rooms.

Residents' meetings had been reduced from monthly meetings to three monthly without any evidence of consultation and agreement with residents.

Judgment: Not 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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: End of life	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Abbey Haven Care Centre & Nursing Home OSV-0000738

Inspection ID: MON-0044875

Date of inspection: 20/02/2025

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Following the Inspection, the Registered Provider carried out a comprehensive review of staffing levels within the Centre, to address concerns raised by Inspectors during the recent inspection of the Centre. In order to ensure that effective staffing levels are maintained within the Centre, the Registered Provider has put in place procedures to ensure, going forward, that Agency Staff will be sourced/engaged to cover staff who fall ill or who are on temporary leave. Since the Inspection the Registered Provider has expedited the recruitment of additional permanent staff within the Centre. Additional HCA staff have commenced employment to support resident care needs. A kitchen assistant has commenced employment to support chef with kitchen duties. An additional cleaning staff member has been selected and is progressing thorough recruitment process to increase cleaning hours. Laundry hours are rostered specifically for laundry duties. Additional staff recruitment to support care and activities is ongoing. The Centre's PIC, supported by the Centre's CNM, will continue to monitor staffing levels within the Centre to ensure that there is a full complement of staff on duty in the Centre on a day-to-day basis, with staff rostering to be overseen by the Registered Provider.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

The Registered Provider and PIC have reviewed the Centre's training needs analysis and the training matrix has been updated to reflect all training completed. The Training matrix will be monitored closely to ensure all staff training is kept up to date.

An external IPC trainer was engaged to support IPC training for all staff areas. Training delivered is specific to Infection Prevention and Control in Nursing Homes. This IPC Training was completed on 7/4/2025 to ensure all staff are upskilled and this will be ongoing. Staff supervision will include monitoring of practice in line with training delivered and National Standards for IPC and HPSC guidelines as updated.

The Link Practitioner (CNM) conducts observational audits of hand hygiene to ensure compliance with best practice. A senior staff nurse has been enrolled to complete IPC Link practitioner training on 12/5/2025. On completion of this Link Practitioner training , an IPC team will be developed to include management team, link practitioners and a staff member from each area (Nurse , HCA, catering and housekeeping) to enhance oversight of IPC within the Centre with regular meetings to monitor IPC compliance.

All nurses have completed cardio pulmonary resuscitation (CPR) training 5/3/2025 as scheduled prior to inspection date.

Dementia, NVPS Responsive Behaviour training was completed on 25/3/25 and is ongoing for new staff. Staff supervision will include monitoring of practice in line with training delivered.

Nutrition: Weight Management MUST Training and Dysphagia was completed on 27/3/2025 – additional training is planned to ensure new staff are upskilled.

Wound care management and assessment training has been completed on 23/4/2025 for PIC , CNM and nursing staff to ensure knowledge and skills are updated with requirements of evidence-based practice. Management team will oversee wound management to include supervision of nursing staff delivering wound care and ensure timely referrals to Tissue Viability Nurse and General Practitioner.

Assessments and care plans will be reviewed and where issues are identified , a meeting will be held with the responsible nurse who will be required to amend assessments and care plans within a specific time frame. Additional care plan training will be provided to address identified gaps to ensure care plans meet standards .

Falls Prevention training is planned to take place on a near date to be determined. In the interim, a safety pause regarding falls prevention is incorporated into the handover daily, to alert staff of residents who are at risk of fall or have had a recent near miss event / fall event. The requirement for maximising supervision while upholding residents right to privacy and positive risk taking is continued at handover daily.

Staff supervision: Regular on the floor scheduled supervision sessions and spot checks by Provider/ PIC and CNM will be conducted to monitor staff compliance in critical areas: resident monitoring , IPC practices , nutritional / fluid intake , skin integrity / wound care, falls management, meaningful activities and the need for revision of care plans.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider has taken the following actions to ensure full compliance under Regulation 23 in respect of the following management/oversight areas:

In order to ensure robustness in the clinical governance of the Centre going forward, the Registered Provider has committed to amend the management structure of its Centre to ensure the creation of a new senior clinical role within the Centre to be called the Director of Nursing (DON), the DON will support the PIC to ensure oversight of all services and support same in the day-to-day operation of the Centre. In anticipation of the selection and appointment of a full time DON to support governance and oversight within the Centre, a professionally qualified member of the Board of directors of the Registered Provider will fulfill the duties of clinical oversight role pro temp.

A review of all staffing allocations is underway in the centre to ensure that resources and skill mix are assigned in the most suitable way for the delivery of care to the resident's need. Allocations are completed on a daily basis by the CNM.

The Registered Provider, PIC and Link Practitioners will implement and monitor infection control practices in the centre consistent with the National Standards for Infection Prevention and Control and HPSC Guidelines for Residential Care . Results of Observational audits by IPC Practitioners and staff supervision of staff practices will be used for training and quality improvement of the service.

Risk assessments regarding Falls prevention and management, infections and the occurrence of unexplained bruising will be reviewed and updated in risk register.

The Registered Provider and PIC (supported by CNM) will ensure staff training needs are meet. Staff have received updated training in following areas since inspection : CPR, Infection Prevention and Control for Nursing Homes , Dementia and Responsive Behaviours , Nutrition Awareness and MUST, Dysphagia and Wound Management.

The Registered Provider and PIC will ensure that all mandatory notifications required by reference to Regulation 31/Schedule 4 will be submitted as per Regulations.

Assessments and care plans are been reviewed and where issues are identified , a meeting will be held with the responsible nurse who will be required to amend assessments and care plans within a specific time frame.
Additional training will be provided to address identified gaps and reinforce the needs for a high standards of practice

The Registered Provider, PIC and CNM will ensure that all residents are provided with the information leaflets and verbal explanation to help them make an informed decision regarding Vaccinations offered via HSE. A record will be maintained of the communication and support given. Where the resident is unable to consent , their care representative will be informed and the GP will be consulted. Vaccination is offered to all residents.

Legionella testing was completed on 02/04/2025 and reported 22/4/2025 – Legionella NOT DETECTED.

Governance meetings including the Registered Provider, PIC and CNM are scheduled more frequently presently to address progress in clinical governance and quality improvement.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Following the Inspection, the Registered Provider conducted a full review of compliance within the Centre with the obligations of Regulation 31.
The Registered Provider, in order to address the concerns raised by the Inspectors, has committed resources towards the following effective measures: The Centre's PIC going forward will be supported in her role by the DON (once appointed) and by an officer of the Registered Provider's Board of Directors pro temp until the appointment of the DON.

The Registered Provider has put in place measures, with immediate effect, to ensure that all mandatory notifications required by reference to Regulation 31/Schedule 4 will be submitted by the PIC within the two working day deadline. In particular, power failures will be notified to the Chief Inspector going forward on Form NF09 as will unexpected deaths where they occur. For completeness, following the Inspection, the Registered Provider ensured that the PIC submitted statutory notifications under Regulation 31 by reference to matters of concern identified by the Inspectors during the Inspection.

Regulation 13: End of life	Not Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
End of life Care plans are under review for all residents. Where the resident is unable to communicate End Of Life wishes, the family/ relative representative will be involved to

help devise appropriate plan. Discussion with GP will also be available to residents/ relatives / nominated representative, to ensure end of life wishes for all residents are recorded and implemented.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider conducted a review of all concerns raised by the Inspectors during the Inspection by reference to Regulation 17. The Registered Provider took the following actions:

1. On the day of the Inspection, the Registered Provider took immediate steps to ensure that all residents have easily accessible emergency bells. The Registered Provider put enhanced procedures in place to ensure that all staff report promptly to management all call bell faults and/or deficiencies;
2. The Registered Provider has taken steps to repair and replace (where appropriate) all furniture of concern in the Centre's reception area; and
3. The Registered Provider has reviewed and put in place enhanced measures to ensure that all residents are informed of the Exit Doors to the courtyard so that they have easy access to the enclosed garden.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Following the Inspection, the Registered Provider reviewed all concerns raised by the Inspectors by reference to Regulation 18. The Registered Provider has taken the following actions:

The Registered Provider and PIC (supported by CNM) has put enhanced systems in place to ensure effective communication with staff in relation to Food & Nutrition, including systems to remind staff at handover of the importance of recording food / fluid intake accurately for residents who are being monitored.

All staff are reminded at handover of the importance of accurate recording of portion sizes and fluid intake for residents.
Chef has up to date record of resident's preferences, portion sizes and modified diets to ensure nutrition is optimized through dietary intake. Staff are instructed to offer additional snacks to residents with small appetite and or weight loss. Staff supervision of

mealtimes and dietary intake is ongoing.

Residents with weight loss are highlighted on digital record system as Nutritional watch to alert staff to accurately record portion sizes and for additional snacks to be offered.

Residents with a MUST score of 2 or more will be referred to Dietician for advice. Dietician advice will be actioned . The monthly weight check will be adjusted to weekly or two weekly where weight loss is detected. Where weight loss persists, the resident will be re referred to dietician for advice.
Nursing staff ensure nutritional supplements to fortify dietary intake are offered and recorded. Where a resident is non-compliant with supplements, this is highlighted with dietician and GP for further review to identify alternatives.

Weight loss will discussed be with General practitioner and where weight loss is ongoing, a meeting with the resident / relative / support person will be arranged to discuss further investigations where appropriate.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The Registered Provider conducted a review following the Inspection of all concerns raised by the Inspectors under Regulation 27, and has taken the following actions:

The Registered Provider has made arrangements for all staff within the Centre, to receive focused Education & Training focused on ensuring effective implementation of all procedures within the Centre with current IPC guidelines.

IPC training provided for management and all staff on 7/4/2025. This IPC training program incorporated Infection Prevention and Control , Chain of infection , IPC Standard Precautions and IPC Transmission based precautions, Management of residents displaying respiratory symptoms, multidrug resistant organisms, use of dipstick to determine Urinary tract infection, catheter care. Point of care Risk Assessment, hand hygiene , PPE , management of sharps and cleaning procedures in Nursing Home.

Link Practitioner (CNM) conducts observational audits of hand hygiene practices to ensure compliance with best practice as part of staff supervision. A senior staff nurse has been enrolled to complete IPC Link practitioner training to support PIC and CNM with oversight of IPC and staff supervision in relation to IPC. Training will commence 12/05/2025.
An IPC team will be developed to include Provider, PIC and CNM, link practitioners, HCA and housekeeping staff member. Monthly meetings will be held to review IPC audits, supervision and best practice.

Where two or more residents present with similar RTI symptoms, an outbreak will be suspected, appropriate transmission- based precautions will be implemented for symptomatic residents with sign and symptoms of contagious viral infection.
The General Practitioner will be informed.
Residents will be swabbed for contagious viral infection as per Public Health and Infection Prevention and Control guidance on the prevention and management of cases and outbreaks of respiratory viral infections in Residential Care Facilities as updated.

The Centre's Hand hygiene facilities were reviewed, hand sanitiser units are now installed inside all shared rooms at point of care and additional sanitisers installed in corridors. Designated hand washing areas for staff and clinical hand wash sinks location are been considered.
Expired alcohol gels were removed from the centre and new stock sourced.

Sharps Management has been reviewed and traditional needles have been replaced with safety engineered sharps device to minimise risk of needle stick injury. Sharps boxes are labelled and dated appropriately and monitored to ensure temporary closure is utilized until ready for final closure as per indicated line on sharps box.
The IPC audit includes Sharps management and audit results will be monitored by IPC team / PIC and Registered Provider.

The Provider and PIC, supported by the CNM, will continuously monitor the standard of cleaning within the Centre on a daily basis and supported by a weekly in-house audit,(currently) validated by a monthly audit by the PIC and will be reviewed in monthly Governance meeting. (commenced and ongoing).
Housekeeping hours have been reviewed and increased .The Registered Provider and PIC will ensure that household staff are supervised on an ongoing basis to ensure compliance with the hygiene standards, mindful that additional IPC training was provided to the Centre's staff on 7 April 2025.
The Centre's Catering Manager will monitor the standard of cleaning in the dining area on an ongoing basis

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The Provider , PIC and CNM will ensure staff supervision to oversee residents receive appropriate assistance with their resident's nutritional and hydration needs and accurate intake is recorded.

All nurses and HCAs received training on nutrition and hydration, MUST, and Dysphagia PIC and CNM will ensure all residents nutritional intake including nutritional supplements will be monitored and documented daily.

Dietician referrals / re referrals will be sent for residents with weight loss and dietician advice will be actioned and incorporated into resident's care plan. This will be reviewed in monthly governance meeting.

The Provider , PIC and CNM will monitor wound care management . Residents who have a surgical wound post hospital will have dressing checked and imaged as baseline on return from hospital . The wound dressing will be checked twice daily and changed in line with wound management training and surgical team advice/ GP review.

The Provider, PIC and CNM have revised the care plan of the resident presenting with Responsive behaviour, triggers are identified and positive behaviour support plan is implemented by staff.

The PIC and CNM conducted a meeting with nursing staff to ensure person centred care planning and assessment is reviewed effectively on a resident-by-resident basis when changes occur.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
PIC and CNM of the Centre will ensure that dietician, TVN, Physio and OT referrals and re referrals will be made a timely manner and recommendations are actioned at the earliest opportunity.

Residents skin integrity is checked daily and any changes identified are recorded by nurse /HCA. A skin integrity record is created in digital record system to monitor skin changes. Risk assessment is repeated and action plan implemented. Skin integrity/ wound management is part of staff handover.

A skin integrity weekly wound review has commenced to ensure timely referrals to TVN are completed. This will be validated in the monthly Governance meeting.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
All staff received training in Responsive Behaviours and positive behaviour support

techniques .
Staff will be supervised to ensure positive support training is implemented in practice for residents daily. All staff are encouraged to share their experiences of any triggers for responsive behaviours and positive behaviour support /distraction techniques at handover for individual residents . Care plan records are updated accordingly.

Residents with short attention spans for activities and periods of engagement will receive positive behaviours supports from staff . Staff will encourage personalised meaningful activities / non pharmacological therapy in line with residents' preference as distraction techniques.

At daily handover, staff are alerted to residents who have tendency to enter other resident's rooms uninvited , residents are redirected using gentle distraction approach and are redirected to their own bedroom.

Residents will be further supported by relative / NOK , GP , Psychiatry of Late Life and/or Geriatrician as required .

The courtyard garden can be accessed by residents through all nine fire doors by pushing the doors open. Residents who were wandering in the Centre on the day of the Inspection have been assessed clinically as pleasantly wandering in a safe environment.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Residents' daily routines will be determined by individual resident preference and recorded in care plan.

All residents are afforded the choice to have their breakfast in the dining room of the Centre or in their bedroom, depending on their preference.
Residents' preference regarding mealtimes is recorded in their dietary sheet and is updated in accordance with changes to preference. Residents can have their meals in a location of their choice at any time, dining room, bedroom or other area.

All nine fire exit doors can be pushed open to permit more easy access to the enclosed garden for residents going outdoors.

Emergency call bells are accessible for all residents, staff have been informed to report any call bell fault in maintenance book at reception.
Resident's preferences to pursue their interests on an individual basis or participate in

group activities in accordance with their interests is been revised and care plans updated.
The Centre has ceased the practice of sitting a resident in coustmised chairs with a hoist sling in place, with a view to promoting the comfort/dignity of all residents . Staff have been educated and are aware not to sit residents in their chair with hoist slings in place.
Clinical Nurse Manager / Senior Nurse on duty will monitor practice in this regard.
Layout of the twin rooms are designed to ensure residents privacy, and to enable access to ensuite facilities without entering into the other residents' space.
Resident's meetings will be carried out on a monthly basis going forward, if residents' preference on the frequency of meetings changes, same will be recorded on a monthly basis as evidence of consultation.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Not Compliant	Orange	30/04/2025
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/05/2025
Regulation 16(1)(a)	The person in charge shall	Not Compliant	Orange	30/04/2025

	ensure that staff have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2025
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	31/05/2025
Regulation 18(1)(a)	The person in charge shall ensure that each resident has access to a safe supply of fresh drinking water at all times.	Substantially Compliant	Yellow	31/03/2025
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	31/03/2025
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional	Not Compliant	Orange	30/04/2025

	assessment in accordance with the individual care plan of the resident concerned.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Not Compliant	Orange	30/04/2025
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.	Not Compliant	Orange	30/04/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Not Compliant	Orange	31/05/2025

	infections published by the Authority are implemented by staff.			
Regulation 31(1)	Where an incident set out in 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.	Not Compliant	Orange	31/03/2025
Regulation 31(2)	The person in charge shall ensure that, when the cause of an unexpected death has been established, the Chief Inspector is informed of that cause in writing.	Not Compliant	Orange	31/05/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/05/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after	Not Compliant	Orange	31/05/2025

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.	Not Compliant	Orange	31/05/2025
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.	Not Compliant	Orange	31/05/2025
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	Not Compliant	Orange	31/05/2025

	paragraph (1) or other health care service requires additional professional expertise, access to such 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.	Not Compliant	Orange	31/05/2025
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	31/05/2025
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	31/05/2025
Regulation 9(2)(b)	The registered provider shall provide for residents	Not Compliant	Yellow	31/05/2025

	opportunities to participate in activities in accordance with their interests and capacities.			
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	Yellow	31/05/2025
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.	Not Compliant	Yellow	31/05/2025
Regulation 9(4)	The person in charge shall make staff aware of the matters referred to in paragraph (1) as respects each resident in a designated centre.	Substantially Compliant	Yellow	31/05/2025