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:	Mount Hybla Private
Name of provider:	Mount Hybla Nursing Home Limited
Address of centre:	Farmleigh Avenue, Farmleigh Woods, Castleknock, Dublin 15
Type of inspection:	Unannounced
Date of inspection:	22 May 2025
Centre ID:	OSV-0000744
Fieldwork ID:	MON-0046363

About the designated centre

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

Mount Hybla Nursing Home Limited, operates Mount Hybla Private a modern purpose-built centre situated in Castleknock, Dublin 15. The centre is located in a residential development a short distance from shops, cafes and pubs. General nursing care is provided for long-term residents, people living with physical disabilities and acquired brain injury. Respite and convalescence care can also be provided for people aged 18 years and over. The person in charge, assistant director of nursing and clinical nurse managers lead a team of nurses and healthcare assistants and support staff to provide all aspects of care. Palliative and dementia care can also be provided and there is access to a specialist geriatrician, psychiatry and a physiotherapist. The centre can accommodate up to 66 residents, in single en-suite bedrooms available over two floors. Lavender is a 16 bed dementia care unit on the ground floor which has a central courtyard and its' own communal space.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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 22 May 2025	08:55hrs to 18:00hrs	Aisling Coffey	Lead

What residents told us and what inspectors observed

The feedback from residents was that they were very happy and liked living in Mount Hybla Private. The residents spoken with expressed high praise for the staff, management and the care and attention they received. Residents described the staff in complimentary terms, including "lovely" and "wonderful", with one resident informing the inspector, "the staff could not be nicer". In terms of the centre itself, residents were similarly complimentary, telling the inspector, "I like it here" and "it's like home". Visitors who spoke with the inspector provided equally positive feedback, referring to the high level of care received by their loved ones and the communication with them as family members. The inspector observed warm, kind, dignified and respectful interactions with residents and their visitors throughout the day by staff and management. Staff and management were knowledgeable about the residents' needs, and it was clear that they promoted and respected the rights and choices of residents living in the centre.

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

The centre was a three-storey building located in a cul-de-sac in Castleknock, Dublin 15. The basement contained staff facilities, storage and laundry areas. Resident accommodation was set out on the ground and first floors. On the ground floor, two suites, Rose and Lavender, accommodated 32 residents. Lavender was a dementia care unit. On the first floor, two suites, Orchid and Magnolia, accommodated 34 residents.

Overall, the inspector observed that the physical environment allowed for care to be provided in a non-restrictive manner. Residents could mobilise through the ground and first floors of the centre. Residents and visitors wishing to travel between the ground and first floors used two passenger lifts. These passenger lifts facilitated unrestricted access between the ground and first floors but restricted access to the basement floor containing staff facilities. While the Lavender suite was secured with keypad access, the keypad code was displayed in the colourful butterfly sticker beside the entrance door. Notwithstanding this good practice, the inspector found the Orchid assisted bathroom, located adjacent to the first-floor dining and sitting room areas, had a keypad lock on the door. This meant this toilet facility was not readily accessible to residents without the assistance of staff to unlock the door for them. The rationale presented for this restricted access did not provide evidence that the residents were consulted about this practice or that the impact on residents was recognised.

Bedroom accommodation was of a high good standard. All bedrooms had en-suite shower, toilet and wash-hand basin facilities. Bedrooms had a television, call bell,

wardrobe, seating and locked storage facilities. Residents had personalised their bedrooms with photographs, artwork, religious items, ornaments and furniture from home. The size and layout of the bedroom accommodation were appropriate for resident needs.

Internally, the centre's design and layout supported residents in moving throughout the centre, with wide corridors, sufficient handrails, furniture and comfortable seating in the various rest areas and communal areas. These communal areas included a large dining room, a smaller dining room, an oratory, an activity room, a sitting room and a café on the ground floor. There was a sitting room and dining room on the first floor. A hairdressing area was also available for residents. The ground floor café was seen to have tea and coffee-making facilities for residents and their visitors to enjoy.

Regarding outdoor space, the centre had three very well-maintained landscaped outdoor areas. There was a pleasant terrace and sensory garden at the front of the centre. This area had garden ornaments, furniture and sunshades for residents and visitors. There were two smaller internal courtyards located in Rose and Lavender suites. The Lavender courtyard was pleasantly landscaped with raised planters, flowering plants, trellises, and garden furniture.

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

The centre was found to be very inviting and pleasantly decorated throughout, providing a comfortable and homely atmosphere. Photographs of residents and staff enjoying group activities and outings were displayed alongside residents' artwork on the walls. Notwithstanding these positive aspects, the décor in some parts of the premises showed signs of wear and tear. While the centre's interior was very clean on the inspection day, some storage practices required further improvement. These matters are discussed under Regulation 17: Premises and Regulation 27: Infection control.

The inspector noted some fire safety concerns while walking the premises. For example, some doors were seen to be propped open with a box and a cover for a floor electrical panel, while escape corridors on the basement floor were not kept clear. These matters are discussed under Regulation 28: Fire precautions.

On the morning of the inspection day, residents were up, dressed in their preferred attire and appeared well cared for. The hairdresser was present, and residents proudly displayed their new hairstyles. There was also a physiotherapist on duty who was seen attending to residents on an individual basis. A range of recreational activities were available to residents seven days a week. There were two activities coordinators on duty on the morning of the inspection. The inspector observed 11 residents enjoying a high tea in the Lavender day space in the morning. The area was observed to be very calm and peaceful, with soft music playing, sensory lamps

lighting and relaxing imagery being broadcast on the television. On the first floor, the inspector observed one-to-one nail manicures taking place in the sitting room. These activities were followed by exercises in the activity room before lunch. In the afternoon, there was great laughter and lively discussion heard from the sensory garden, where 25 residents and some visitors were enjoying ice cream while engaging in an activity around Irish proverbs. Residents told the inspector they were happy with the range of activities and entertainment available. Those who chose not to engage in group-based activities were seen reading newspapers and books, listening to the radio and watching television in the comfort of their bedrooms and the multiple communal areas within the centre.

The inspector observed the dining experience in the centre over lunchtime at 1:00pm. While the residents who dined in the main dining area had a pleasant, comfortable and sociable dining experience, improvements were required in how meals were served to residents of the Lavender suite. Menus were displayed in the main dining room and residents confirmed they were offered a choice of hake and lamb for lunch. Residents spoken with said they were very satisfied with the food available. Meals were prepared freshly onsite and appeared nutritious and appetising. Residents who required assistance at mealtimes were observed to receive this support in a respectful and dignified manner. There were ample drinks available for residents at mealtimes and throughout the day. Notwithstanding these positive aspects, the inspector found immediate action was required to ensure the dietary needs of residents were safely, effectively and accurately met. This matter and the Lavender dining experience are discussed under Regulation 18: Food and nutrition.

Visitors were observed coming and going throughout the day. Residents and their visitors confirmed there were no restrictions on visiting. Visitors were observed engaging in the activities alongside their loved ones in the sensory garden area and spending time with their loved ones, either in the residents' bedrooms or in the various communal areas. Visitors spoken with were highly complementary of the staff and happy with the care provided to their loved ones.

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

Capacity and capability

While governance and management systems were in place to oversee the quality of care delivered to residents, and improvements were evident since the 20 June 2024 inspection, further actions were required to ensure the service provided was safe, appropriate, consistent and effectively monitored, as referenced within this report.

This was an announced inspection to monitor the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended) and to review the registered provider's compliance plan arising from the June 2024 inspection. The registered provider had progressed with the compliance plan, and improvements were identified in medication management, safeguarding of residents' finances and notification of incidents.

Following this inspection, further improvements were required concerning several regulations, including fire precautions, as outlined in the report. An immediate action concerning food and nutrition was issued on the afternoon of the inspection. The inspector observed that a resident who was prescribed a modified consistency diet was served an inappropriate diet, which posed a safety risk. This was immediately brought to the attention of the nursing staff and the person in charge. The person in charge arranged for an immediate review of all meals served to ensure the dietary needs of residents prescribed by a healthcare professional were safely, effectively and accurately met.

Mount Hybla Nursing Home Limited is the registered provider for Mount Hybla Private. There are two company directors, one of whom is the group director of operations and represents the provider regarding regulatory matters. The person in charge reported directly to the director of operations.

Since the last inspection on 07 August 2024, there have been several changes in the governance and management of the centre, including the appointment of two persons participating in management to support the person in charge in their operational management and clinical oversight of the centre. At the time of the inspection, the Office of the Chief Inspector had yet to receive full and satisfactory information regarding one of the newly proposed persons participating in management. This matter is referenced under Registration Regulation 6: Changes to information supplied for registration purposes.

The person in charge worked full-time in the centre and was supported in their management role by two clinical nurse managers. Other staff members included nurses, healthcare assistants, a physiotherapist, catering, housekeeping, maintenance and administration staff. The assisted director of nursing (ADON) role had been vacant for six weeks on the day of the inspection. The provider was in the process of recruiting for this position. In the interim, the provider covered the position with clinical nurse managers who deputised for the person in charge.

The registered provider put systems in place to monitor the quality and safety of care. Communication systems were in place between the registered provider and management within the centre. Minutes of monthly operational management meetings and quarterly clinical governance meetings were seen to review key aspects of care provision for residents, including premises, facilities, staff training, complaints, risk management and regulatory compliance. The person in charge prepared a comprehensive weekly report for the provider on key issues within the centre, including occupancy, clinical needs, incidents, human resource matters, fire safety and infection control. Similarly, within the centre, there was evidence of

communication between the person in charge and staff at the ward level. During these meetings, key issues relating to the quality and safety of the service delivered to residents were discussed, such as falls, premises, activities, skin care, wound management, medication management, care planning, nutrition and infection control.

The provider had multiple management systems to monitor the quality and safety of service provision. A risk register was used to monitor and manage known risks in the centre. The provider had oversight of incidents, and there was evidence of tracking and trending incidents such as falls. Notifiable incidents were seen to have been reported to the Chief Inspector within the required timeframes. The provider had an audit schedule covering multiple areas such as staff training, safeguarding, cleanliness, laundry, IPC and medication management. The provider monitored key performance indicators relating to areas, including nutrition, restrictive practices, and complaints. Each of these oversight systems had a time-bound action plan recorded where a risk was identified, with a named person responsible for each action. Notwithstanding these multiple assurance systems, some actions were required to improve these oversight mechanisms to effectively identify deficits and risks in service provision and drive quality improvement. This will be discussed under Regulation 23: Governance and management.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2024. The inspectors saw evidence of the consultation with residents and families reflected in the review. With this review, the registered provider had also identified areas requiring quality improvement.

The provider had recently contracted a fire safety consultant to conduct a fire safety risk assessment a month before the inspection. This assessment identified risk areas, including containment, procedures for kitchen and laundry staff, the requirement for a fire door audit, and remedial actions and improvements to emergency lighting. As this assessment report had been recently received, the provider had not developed a time-bound action plan to address these risks by the inspection day. The provider is required to submit a time-bound action plan for all fire safety risks identified to the Chief Inspector. When all work is complete, the provider must submit an appropriate sign-off from a competent person to confirm that all fire safety risk assessment actions have been addressed.

Registration Regulation 6: Changes to information supplied for registration purposes

While the registered provider had informed the chief inspector of a newly proposed person participating in management, the chief inspector had not been supplied with full and satisfactory information regarding the matters set out in Schedule 2 regarding the newly proposed person participating in management within the required timeframes.

Judgment: Substantially compliant

Regulation 15: Staffing

Based on a review of the worked and planned rosters and from speaking with residents, sufficient staff of an appropriate skill mix were on duty each day to meet the assessed needs of the residents. At night, there were two registered nurses in the centre.

Judgment: Compliant

Regulation 23: Governance and management

While the provider had management systems to monitor the quality and safety of service provision, these governance and oversight arrangements required significant improvement to ensure the service was safe, consistent, effectively monitored and operated in line with the regulations, as evidenced by the findings below:

- The management systems that provided assurance regarding food and nutrition were ineffective. Consequently, an immediate action was issued to the provider on the afternoon of the inspection to ensure all meals served to residents were in line with recommendations prescribed by a healthcare professional. When the matter was brought to the provider's attention, the person in charge arranged for this immediate review.
- The provider's assurance systems had not been fully effective in identifying deficits and risks concerning premises, infection control, and fire precautions, as found on the inspection day.

While staffing levels were appropriate to meet residents' needs on the inspection day, the staff resources available were not in line with those set out in the statement of purpose against which the provider was registered to operate. The inspector was informed of an assisted director of nursing (ADON) vacancy, dating back to early April 2025, for which the provider was in the process of recruiting. In the interim, the provider was covering the position with clinical nurse managers who deputised for the person in charge.

Judgment: Not compliant

Regulation 31: Notification of incidents

Records reviewed found that incidents, as set out in schedule 4 of the regulations, were notified to the Chief Inspector within the required time frames.

Judgment: Compliant

Quality and safety

The inspector observed kind and compassionate staff treating residents with dignity and respect. Residents' rights were upheld in the centre, and visiting was promoted and facilitated. A residents' guide containing the required information was available. Residents were supported in accessing and retaining control over their personal property and possessions. Notwithstanding these positive aspects, this inspection found that enhanced governance and oversight were required to improve the quality and safety of service provision. Robust action was required concerning food and nutrition and fire precautions. Improvements were also required regarding infection control and premises, as outlined in the report.

Overall, the premises' design and layout met residents' needs. The centre was found to be inviting and very pleasantly decorated to provide a homely atmosphere. There were multiple comfortable and pleasant communal areas for residents and visitors to enjoy. The centre had three very well-maintained garden areas. Notwithstanding this good practice, action was required to ensure full compliance with Schedule 6 requirements, which will be discussed under Regulation 17: Premises.

Residents spoken with expressed high praise for the food offered in the centre. Food was prepared and cooked onsite by the centre's chef. Choice was offered to residents at mealtimes, and adequate quantities of food were served. Residents also had access to fresh drinking water and other refreshments at mealtimes and throughout the day. There was adequate supervision and discrete, respectful assistance at mealtimes. Notwithstanding this good practice, the inspector was not assured that food was properly and safely prepared, cooked and served, and improvements were required in how meals were served to residents of the Lavender Unit. These matters will be discussed under Regulation 18: Food and nutrition.

The provider had systems to oversee the centre's infection prevention and control (IPC) practices. The provider had a registered nurse trained as an IPC link practitioner to guide and support staff in safe IPC practices and oversee performance. Resident accommodation was very clean and tidy. There was surveillance of healthcare-acquired infections and antibiotic consumption in the centre. A targeted infection control auditing programme was undertaken. Records reviewed found all staff had undertaken IPC training, with additional training in antimicrobial stewardship having been undertaken by registered nurses. While acknowledging these good practices, some areas required attention to ensure residents were protected from infection and comply with the *National Standards for*

Infection Prevention and Control in Community Services (2018) and other national guidance concerning IPC, as set out under Regulation 27: Infection control.

The provider had systems to monitor fire safety. Preventive maintenance for fire detection, fire fighting equipment and emergency lighting was conducted at recommended intervals. Procedures to be followed in the event of fire were prominently displayed. Staff had undertaken fire safety training and participated in monthly fire evacuation drills. Each resident had a personal evacuation plan to guide staff in an emergency requiring evacuation. There was a system for checking the fire alarm and means of escape. Lint removal records were kept in the laundry room. A sample of fire doors were observed to be in good working order. As referenced in the capacity and capability section, the provider contracted a fire safety consultant to conduct a fire safety risk assessment, which identified several risks the provider would be required to take action on. While there was evidence of these good practices, further robust actions were required to protect residents against the risk of fire and to ensure staff could respond appropriately in the event of a fire. These findings are set out under Regulation 28: Fire precautions.

Regulation 11: Visits

The provider had a written visitor policy as required by the regulation. The inspector observed that visits to the centre were encouraged. The visiting arrangements in place did not pose any unnecessary restrictions on residents. The registered provider had several private and communal spaces for residents to host a visitor.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported in accessing and retaining control over their personal property and possessions. Residents had ample space to store and maintain their clothing and possessions. Residents had access to lockable storage facilities in their bedrooms for valuables. The centre had a tidy, well-organised onsite laundry for laundering residents' clothing. Residents were complimentary about the laundry service received in the centre.

While the provider did not act as a pension agent for any residents, the provider held small quantities of money in safekeeping for two residents at their request. The provider had a robust and transparent system where all lodgements and withdrawals of residents' personal funds were accounted for by two persons and recorded on the provider's electronic record management system. The balances available to residents were also seen to be audited regularly.

Judgment: 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, repair and review to be fully compliant with Schedule 6 requirements, for example:

- Some areas showed signs of wear and tear; for example, in the ground floor dining area, the wall adjacent to the emergency exit appeared damp, with peeling paint and loose plaster falling from the wall.
- Some areas in the centre had damaged flooring covered with tape.
- The lock to the outer cupboard containing the controlled drug press was broken, with staff being unable to lock it.
- The Orchid assisted bathroom had a keypad lock, meaning this facility was inaccessible to residents without staff assistance to unlock the door.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector observed that the mealtime experience for residents required review to ensure that food and nutrition were delivered in line with the regulatory requirements.

The inspector was not assured that food was properly and safely prepared, cooked and served due to the following findings:

- Food was not provided to residents in line with their assessed dietary needs. For example, a resident who was prescribed a modified consistency diet was served a meal of the incorrect consistency, which posed a safety risk. This was immediately addressed during the inspection when the inspector brought this to the attention of the nursing staff and the person in charge.
- Two items of plated food from the breakfast meal were found in a microwave at 12:05pm.
- Cleanliness within the first-floor kitchenette required robust attention as the following were observed to be visibly unclean: trolleys containing food trays for residents' meals; some tableware such as teapots, some cupboards and a fridge.

While the residents who dined in the main dining area had a pleasant, comfortable and sociable dining experience, improvements were required in how meals were served to residents of the Lavender Unit. The inspector found that several residents, who were reported to have expressed a preference to eat in the Lavender day

space, and not in the main dining room, were bending forward from their armchairs to eat from low tables. These tables were not suitable for eating meals from, and residents leaning forward appeared uncomfortable. The practice of serving meals in the same day space area where many of the residents spent their day also did not facilitate them to have their meal served comfortably at a dining table, with the opportunity for social engagements with other residents and staff over their meal.

Judgment: Not compliant

Regulation 20: Information for residents

A comprehensive guide for residents was available in the centre. This guide contained information for residents about the services and facilities provided, including the complaints procedures, visiting arrangements, social activities and many other aspects of life in the centre.

Judgment: Compliant

Regulation 27: Infection control

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

The decontamination of resident care equipment required review, for example:

- A number of staff informed the inspector that the contents of commodes were manually decanted into the sluice hopper before being placed in the bedpan washer for decontamination. Decanting risks environmental contamination with multi-drug resistant organisms (MDROs) and poses a splash/exposure risk to staff. Bedpan washers should be capable of disposing of waste and decontaminating receptacles.

Storage practices posing a risk of cross-contamination required review, for example:

- A basement store room contained clinical equipment used by residents, including wheelchairs, mobility aids, crash mats and pressure cushions. It was unclear if the equipment was clean or dirty, and there was no identifiable mechanism to determine this. Some of the clinical equipment was visibly stained with dried-in food and liquid staining. The centre requires a system to distinguish between clean and dirty equipment to ensure equipment is clean before being given to a resident.

- Clean items such as duvets were stored alongside dirty items such as hoovers, a buffer, and dustpans in the basement-level cleaner's store room.
- Store rooms throughout the centre had objects and boxes stored directly on the floor, impacting the ability to clean these areas effectively.

Judgment: Substantially compliant

Regulation 28: Fire precautions

As referenced in the capacity and capability section, the provider is required to submit a time-bound action plan to the Chief Inspector for all identified fire safety risks referenced in the fire safety risk assessment conducted on 18 April 2025. When all works are complete, the provider must submit an appropriate sign-off from a competent person to confirm all actions have been addressed.

In addition to these identified risks, the provider was required to take robust action concerning several fire safety matters identified on the inspection day, as outlined below.

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

- The inspector found three doors propped open by means other than appropriate devices connected to the fire detection and alarm system. This included an office door and a staff canteen door held open by a box and a cover for a floor electrical panel in a non-resident area. Additionally, the first-floor sitting room door had an armchair that prevented the door from closing in the event of the fire alarm activating. Staff immediately moved the position of the armchair in the first-floor sitting room when it was brought to their attention.
- There were several holes in the ceilings around pipe and wire penetrations, which posed a risk to containment should a fire occur. These matters were noted in multiple areas, including the ESB room, comms room, first-floor pharmacy store, a first-floor store room and the lobby adjacent to the kitchen.

The provider's arrangements for ensuring all staff were aware of the evacuation procedures and the building layout required review as not all staff knew the centre's fire compartment boundaries:

- The inspector found that staff spoken with were unclear about the compartment boundaries within the centre.
- This lack of clarity was also reflected in the centre fire drills. For example, a fire drill taking place on 19/05/2025 refers to compartment 14 having five bedrooms when the compartment had eight bedrooms. Similarly, a drill taking

place on 26/08/2024 referred to compartment five as having five bedrooms when the compartment had eight bedrooms.

Further assurances were required to assure the provider that residents could be evacuated in a safe and timely manner in the event of a fire emergency, for example:

- The provider's emergency procedure detailed progressive horizontal evacuation approaches, but there was no reference to vertical evacuation procedures to guide staff.
- While fire drills occurred monthly, vertical evacuation had not been practised.
- The centre had three stairwells. Two of the stairwells had one evacuation aid to facilitate a vertical evacuation, while the third staircase did not have any evacuation aid. The inspector spoke with staff and reviewed personal emergency evacuation plans (PEEPs), which found that the majority of first-floor residents would not be able to mobilise down a set of stairs in a fire emergency. Therefore, the provider was required to review the number of evacuation aids in the centre to ensure there were adequate arrangements in place to support a safe and timely vertical evacuation at all times.

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

- In the ground floor treatment room, hoist batteries were charging within a short distance of oxygen cylinders. Similarly, items were charging near oxygen cylinders in the first-floor pharmacy store.
- A hoist battery was being charged on a bedroom corridor in the Lavender suite. Charging hoist batteries on a bedroom corridor introduces a fire risk to this protected escape route.
- In the first-floor pharmacy store, nutritional supplements were stored directly under and surrounding electrical panels. A risk assessment is required by a competent person to determine the appropriate controls required to manage the risk when using this area for storage.
- In the first-floor store room, a cleaning trolley containing flammable liquids was seen located against an open electrical distribution board.
- Staff were unaware of the procedure to be followed to shut off the gas in the laundry.

The arrangements for maintaining means of escape required review, for example:

- A new cleaning trolley was observed to be stored in the stairwell adjacent to the archive room, while 56 large boxes of incontinence wear were seen in the corridor on the basement floor. These practices could impact the corridors and stairwells being used as a means of escape in an emergency. Escape routes must be kept free of obstruction and inappropriate storage.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had ensured that a pharmacist of the residents' choice was available to each resident. Medication administration was observed, and the inspector found that the staff had adopted a person-centred approach. The records reviewed found that medicines were administered in accordance with the directions of the prescriber. There were appropriate procedures for handling and disposing of unused and out-of-date medicines. The inspector noted that the medication trollies were secured at all times.

While there were robust measures in place for the handling and storage of controlled drugs in accordance with current guidelines and legislation, the inspector found the lock to the outer cupboard containing the locked controlled drug press within to be broken and was therefore not locking. This matter is referenced under Regulation 17: Premises.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that residents' rights were upheld in the centre. Staff were seen to be respectful and courteous towards residents. Residents' privacy within their bedrooms was seen to be respected. The centre celebrated fortnightly religious services in-house. The centre also had an oratory for quiet reflection. Residents could communicate freely, having access to telephones and internet services throughout the centre. Residents had access to independent advocacy services.

There was a varied and interesting activities programme available, supplemented with regular themed events, such as "mocktails and music", coffee mornings, St Patrick's Day festivities and "Valentine's bingo". The provider facilitated residents' access to community groups like the local heritage society. Outings had been organised to the zoo.

Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents' meetings and completing residents' questionnaires. The records reviewed found that residents' questionnaires had been analysed, and an action plan had been developed. Similarly, records reviewed found extensive and genuine consultation with residents at committee meetings with robust action planning on suggestions brought forth by residents in relation to matters such as food, activities, care provision and the premises.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 6: Changes to information supplied for registration purposes	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mount Hybla Private OSV-0000744

Inspection ID: MON-0046363

Date of inspection: 22/05/2025

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**
Registration Regulation 6: Changes to information supplied for registration purposes	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: All documents and information relating to the newly proposed persons participating in management have now been submitted.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Nursing Home has reviewed all quality assurance systems that were in place which were not fully effective. All quality systems have been reviewed and updated to include new daily Clinical Governance templates for the Management team in the home to use. • The system has been reviewed since the inspection, and all staff have been retrained on IDDSI (International Dysphagia Diet Standardisation Initiative). This training is now included as part of the staff induction process. Residents are provided with daily meal choices, and the menu clearly outlines the required food consistency levels for both catering and care staff to follow. A detailed, individualised food plan has been provided to the catering department for each resident, ensuring consistency and safety in meal preparation. • The Nursing Home has a clear governance and management system in place. This is supported by weekly reports to the Senior Management Team, monthly operational meetings and the regular monitoring of key performance indicators, (KPIs) across various aspects of care provision. In addition, quarterly clinical governance meetings, quarterly	

health and safety meetings, and quarterly resident committee meetings are held within the home.

• The resident committee meetings are conducted by the Person in Charge (PIC), with the Head Chef in attendance to receive direct input from residents. When residents make special requests, the chef meets with them personally to ensure appropriate arrangements are made.
• Daily menu selections include detailed meal requirements, including food consistency levels. A tailored food plan is provided to the kitchen for each resident. IDDSI (International Dysphagia Diet Standardisation Initiative) and food consistency training are included as part of staff induction. All staff have been retrained on this topic via an online platform.
• Additionally, one of the service providers has delivered in-house training to ensure staff are fully informed and capable of maintaining food safety standards, thereby reducing the risk of future errors.

• A deep clean of all equipment was conducted following the inspection and signed off by the household manager and Director of Nursing.
• An updated cleaning checklists has been put into place to ensure a more robust auditing system with oversight from the Director of Nursing.
• An updated plan of deep cleaning has been put in place.
• Twice weekly meetings with the Director of Nursing and Household supervisor are held to discuss any concerns or issues identified.

• All doors propped open in the non-resident area by means other than appropriate devices connected to the fire detection and alarm system were removed. The armchair holding open the first-floor sitting room door was removed.

• A new daily walk around template has been implemented within the home. This is completed by the Director of Nursing / ADON each day. This template helps identify and issues within the home which can be actioned immediately. Staff can be notified of any issues and learnings implemented straight away. Members of the SMT will also conduct the walk around when in the home.

• Holes in the ceilings around pipe and wire penetrations, which posed a risk to containment should a fire occur have been repaired.

• The company has a SLA with an external maintenance company who carry out repairs on a quarterly basis. They also provide support and repairs to any issues arising that the loacl Maintenance personnel cannot achieve.

• The Assistant Director of Nursing has commenced in the Nursing Home.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Environmental Checks are conducted in the home regularly. Any issues identified are written up and action plan devised. Issues identified on the day of inspection had been identified in the above checks and planned repairs scheduled.
The ground floor area dining wall adjacent to the emergency exit has been repaired.
The home has full flooring plan in place to repair and replace damaged areas throughout the Nursing Home.
The lock to the outer cupboard containing the controlled drug press has been repaired by maintenance.
The assisted bathroom keypad has been removed. This bathroom is now accessible to all residents if required

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The systems have been reviewed since the inspection, and all staff have been retrained on IDDSI (International Dysphagia Diet Standardisation Initiative). This training is now included as part of the staff induction process. Residents are provided with daily meal choices, and the menu clearly outlines the required food consistency levels for both catering and care staff to follow. A detailed, individualised food plan has been provided to the catering department for each resident, ensuring consistency and safety in meal preparation.

• A deep clean of all equipment within the first-floor kitchenette was conducted following the inspection and signed off by the household manager and Director of Nursing.
• A deep clean of trolleys containing food trays for residents' meals, tableware some cupboards and a fridge was conducted following the inspection.
• An updated cleaning checklists with the above items has been put into place to ensure a more robust auditing system with oversight from the Director of Nursing.
• An updated plan of deep cleaning has been put in place.
• Twice weekly meetings with the Director of Nursing and Household supervisor are held to discuss any concerns or issues identified.
• The two food items that were found in the microwave were immediately discarded upon discovery to prevent any potential food safety risk. Staff present at the time were reminded of the importance of promptly clearing and checking kitchen and food preparation areas after each mealtime.
• All kitchen and care staff have been reminded of the importance of food hygiene and timely clearance of food items. This was reinforced in a team meeting held 25/06/2025.
• The Head Chef will conduct random spot checks weekly to ensure compliance with the new procedure.
• Monthly meal audits have now been integrated with food consistency checks to ensure

compliance with proper food consistency practices.
• New dining tables have been ordered for the Lavender unit to facilitate the residents who wish to dine there.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The decanting of contents into the sluice hopper has stopped. All relevant staff have re-completed the required training, and the team lead has been informed to ensure oversight and accountability. Clear written instructions outlining the correct procedures have been placed beside each sluice room to serve as a visual prompt and reinforce best practice.
The updated procedure was discussed during the unit review meeting to ensure all staff understand the expectations. Additionally, a memo detailing the procedure has been circulated to all staff.
Weekly random checks have been introduced and are being conducted by the Assistant Director of Nursing and Clinical Nurse Managers (CNMs) to monitor compliance and identify any areas for improvement.
The basement store room is used to store clinical equipment's. Any equipmets has been put on is cleaned beforehand.
The basement storage area has been thoroughly cleaned to meet hygiene and safety standards. "Cleaned" stickers have been applied to all items to clearly indicate their status. A new cleaning logbook has been introduced to record all cleaning activities. The date of each cleaning is now documented in the logbook for accountability and tracking purposes. This is audited by the Clinical Nurse Managers. This room is now reviewed and only cleaning equipment's included in it.
All duvets stored in this area have been removed. Only items suitable to be stored in the cleaner's store room remain.
All items in the remaining store rooms around the centre that were on the floor have been removed and stored appropriately ensuring that these areas can be cleaned effectively.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
As highlighted in the report the home had engaged with a Fire Safety consultant to carry out a fire safety risk assessment. The Nursing Home acknowledges that it did not complete all works as previously identified. The home has re-reviewed the contents of

the assessment and developing a time bound action plan for all works to be completed by the 5th October 2025.

Once completed the plan will be forwarded to the Chief Inspector.

These works will be completed by competent fire personnel from an external company.

All inappropriate items that were holding open doors in the Head Office Administration have been removed.

The company has engaged with competent fire person for fire proofing the areas identified.

Fortnightly fire drills are being conducted. As part of these drills staff are being informed about the different Compartments throughout the Nursing Home. Staff have also been informed of the Compartments during morning handovers and toolbox talks conducted by the Management team in the home.
A full review of the emergency procedures is currently being conducted. This involves updating the policy and training provided to staff. The Nursing Home has engaged with the company who provides the training to include vertical evacuation from any training going forward in the home.
A full review of all evacuation aids is being carried out in the centre. Once completed additional equipment e.g. Ski pads will be purchased.
The hoist batteries charging points have been removed and placed in an alternative area. All the charging hoist batteries are now removed from corridors.
The nutritional supplements were removed immediately. The nursing home has engaged with external competent person to carry out a risk assessment in this area.
The cleaning trolly was removed from the electrical distribution board and the flammable liquid was also removed.
A new procedure has been rolled out in relation to the procedure to shut off gas in the laundry. All staff have been informed of this and toolbox talk devised for same.

The new cleaning trolly was removed and stored in an appropriate area.
The home had just received its delivery of incontinence wear. These were put away in the appropriate storage areas. Staff informed to put the delivery away into the appropriate storage room as soon as it is delivered to the home.

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
Registration Regulation 6 (3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the centre) within 28 days of the change and supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of any new person participating in the management of the designated centre.	Substantially Compliant	Yellow	01/05/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a	Substantially Compliant	Yellow	30/07/2025

	particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	30/06/2025
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 assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	30/06/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Substantially Compliant	Yellow	30/06/2025

	the statement of purpose.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/06/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	30/06/2025
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is implemented in the designated centre, as required.	Substantially Compliant	Yellow	30/06/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable	Not Compliant	Orange	05/10/2025

	fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/06/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/07/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	05/10/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre	Substantially Compliant	Yellow	05/10/2025

	and safe placement of residents.			