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:	Kenmare Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Kenmare, Kerry
Type of inspection:	Unannounced
Date of inspection:	06 March 2025
Centre ID:	OSV-0000753
Fieldwork ID:	MON-0045960

About the designated centre

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

Kenmare Community Nursing Unit is located on the outskirts of the town of Kenmare. It is registered to accommodate a maximum of 35residents. It is a two-storey building with lift and stairs access to the upstairs accommodation. It is set out in two units: Sheen House located on the ground floor with 19 residents; Roughty House can accommodate 16 residents on the first floor. Residents' accommodation comprises 31 single and two twin bedrooms with en suite shower and toilet facilities. The palliative care family room is adjacent to the palliative care suite bedroom; the family room has a comfortable seating, kitchenette and en suite shower and toilet facilities. Additional assisted bath and toilet facilities are located throughout. Each unit has a dining room, sitting room and quiet rooms for residents to enjoy. Additional seating areas are located in the large foyer and along corridors for residents to rest and look out at the mountains, garden and courtyards. The enclosed gardens and courtyards both upstairs and on the ground floor provide secure walkways, seating and shrubbery for residents leisure and enjoyment. Other resident facilities include a prayer room for quiet reflection, visitors room, physiotherapy gym, occupational therapy room, and hair dressers salon. The service provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence, respite and palliative care is provided, mainly to older adults.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	28

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 6 March 2025	09:30hrs to 17:30hrs	Siobhan Bourke	Lead

What residents told us and what inspectors observed

This inspection took place over one day and was unannounced. The inspector greeted the majority of residents living in the centre and spoke in detail to five residents about their experiences and life in the centre in more detail. The inspector also met with three visitors who gave very positive feedback regarding the care their loved ones received. The majority of feedback from residents was positive. Residents told the inspector that Kenmare Community Nursing Unit was a nice place to live and that staff were kind and caring to them.

Kenmare Community Nursing Unit is a purpose built centre on the outskirts of Kenmare town. The centre is set out in two different units, Sheen House on the ground floor and Roughty House on the first floor. The centre is registered to accommodate 35 residents. At the time of inspection, 28 beds were currently operational with 19 beds in use downstairs in Sheen House and nine (of 16 beds) upstairs is use in Roughty House.

The design and layout of the centre was suitable for its stated purpose, and met residents' individual and collective needs in a comfortable and homely way. Bedrooms and communal spaces were found to be warm, clean and well maintained on the day of inspection. Residents' bedroom accommodation comprised 30 single rooms, two two-bedded rooms and one palliative care suite. All bedrooms had ensuite shower and toilet facilities. The palliative care suite had adjoining living room space that included, showering facilities, seating, sleeping facilities and a kitchenette for family and visitors' use. This room was occupied on the day of inspection. The shared rooms had privacy screens in place to ensure privacy and dignity for residents who may be sharing.

The inspector saw that many residents' rooms were personalised and homely and were decorated with photographs and residents' personal belongings. Residents could access the internal courtyard from a number of bedrooms and all bedrooms were bright and airy. The inspector saw that work had been completed on the ground floor, so that the day room opened out to a secure patio and garden area, that residents could enjoy, when weather permitted. Due to the split level design of the centre, residents on both floors had access to well-maintained outdoor spaces, with great views of the local country side and mountains. The centre also had murals on the walls surrounding the centre, depicting local scenes. The corridors in the centre were wide and provided adequate space for walking. Handrails were available along all the corridors, to maintain residents' safety and independent mobility. One set of cross fire doors had gaps when closed and one set of doors were closing slowly when checked by the inspector. This is outlined further in the report.

The inspector saw that there were plenty communal spaces in the centre for residents' use such as a large dining room, a sitting room, quiet room and activities' room on each floor. A small quiet room upstairs was full of art work created by a

resident. A personal call bell had been provided for this resident, so they could call for attention of staff easily. The inspector saw a number of crash mats and low beds were in use as alternative to bedrails.

The inspector saw that residents were offered plenty drinks and snacks during the day. The lunch time meal on both floors was observed and residents could choose to eat in the dining room or their bedrooms, with many residents choosing to eat in the dining room. The inspector saw that food was nicely presented and residents were offered a choice for their lunchtime meal. Residents gave very positive feedback on the choice and quality of food provided in the centre. The dining experience was observed to be a social one; with residents chatting with staff and each other during the meal. Residents, who required assistance with their meals, were observed to receive this, in an unhurried and respectful manner.

Residents spoke very positively of staff and indicated that staff were caring and responsive to their needs. Throughout the day, staff were observed engaging with residents in a respectful and friendly manner and being kind and courteous to residents at all times. The speech and language therapist was in the centre during the day. The inspector saw that they were supporting residents with communication difficulties, to improve their quality of life by enhancing their communication supports. The speech and language therapist ensured residents had access to specialist electronic devices, that met their needs.

Some residents were living with dementia and were unable to detail their experience of the service, however, they were also observed by the inspector to be content and relaxed in their environment and in the company of other residents and staff. The inspector saw that a local GP was in attendance in the centre during the morning reviewing residents who required it. The pharmacist was also on site during the morning.

Visitors were seen coming and going throughout the day of the inspection and were welcomed by staff. Visitors were highly complimentary of the care given to their relatives and were happy with the visiting arrangements in place.

Activities to ensure residents could avail of opportunities for occupation and recreation were provided in the centre by nursing and care staff, administrative staff and local volunteers. During the morning, a group of residents enjoyed a lively chair exercise session that was led by the administrator. In the afternoon, a small group of residents upstairs enjoyed a sing song with one of the staff, while the residents downstairs had a newspaper reading discussion and chats. The local community school students attended the centre regularly with their therapy dogs. Residents were encouraged to go on outings with their families from the centre. Resident could access a local mass on the televisions in the centre and the inspector saw that some of the televisions in residents' rooms had been changed to larger ones, since the previous inspection. Residents' views on the running of the centre were sought through residents' meetings, that were held regularly in the centre. Minutes provided to the inspector indicated that actions were implemented following

feedback from residents at these meetings. Resident who required it had access to independent advocacy services.

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

Capacity and capability

This one day unannounced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). An application to renew the registration of this centre had been submitted to the Chief Inspector and this inspection would also inform part of the decision making process. Overall, findings of this inspection were that the management oversight of the service required action, to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored. These findings related to governance and management, training and staff development, notification of incidents, complaints, and care planning.

The registered provider of this centre is the Health Service Executive (HSE). The management team operating the day-to-day running of the centre consists of an appropriately qualified person in charge and a clinical nurse manager. They are supported by a team of nursing staff, health care assistants, multi-task attendants, catering, and administrative staff. At a more senior level there is also governance provided by a general manager for older persons, who represented the provider. It was evident that there was a defined management structure in place and the lines of authority and accountability were outlined, in the centre's statement of purpose. The centre also has support from centralised departments, such as finance, human resources, fire and estates and practice development.

The number and skill-mix of staff on duty was more than appropriate to meet the assessed needs of the 28 residents, living in the centre, on the day of inspection. The team providing direct care to the residents comprised four registered nurses on duty daily and a team of health care assistants and multi-task attendants. The director of nursing and a clinical nurse manager were on duty on week days and were supernumerary, to provide support and supervision to the team providing care to residents. From a review of rosters, there had been a significant increase in the registered nursing complement in the centre from 13 Whole time equivalent (WTE) in the statement of purpose for the previous renewal, to 17.6 WTE on the roster. The inspector was informed that this increase in numbers was to support increase in occupancy in the centre from 28 to 35 residents, as the centre is registered to accommodate 35 residents. However, the inspector found that occupancy in the centre remained at 28 residents.

There was an ongoing comprehensive schedule of training in place, to ensure all staff had relevant and up-to-date training to enable them to perform their respective

roles. A training matrix was maintained to monitor staff attendance at training provided. On review it was evident that the majority of mandatory training was up-to-date for staff with regard to fire safety, safeguarding, managing responsive behaviour and manual handling. However, as evidenced by the standard of care planning records reviewed, further training was required with regard to care planning for nursing staff. These and other findings are outlined under Regulation 16 Training and staff development.

A range of audits were carried out which reviewed practices such as care planning, medication management, infection control and responsive behaviour. However disparities between the high level of compliance found on local audits of care planning with the inspection findings warranted review as outlined under Regulation 23; Governance and management.

There was a complaints policy and procedure in place. The policy had a nominated complaints officer and review officer as required and the procedure was displayed in the centre. The complaint register was reviewed by the inspector and it was evident that complaints were being recorded. However, the inspector was not assured that all complaints were being robustly investigated and written responses provided as required. This is detailed under Regulation 34 Complaints procedure.

The inspector reviewed the records of incidents maintained in the centre and it was evident that required three day notifications were submitted. From a review of a sample of care records, it was evident to the inspector that required quarterly notifications related to pressure ulcers had not been submitted for the last quarter of 2024. The person in charge was requested to submit these on the day of inspection. This is actioned under Regulation 31 Notification of incidents.

A comprehensive annual review of the quality and safety of care provided to residents in 2024 had been prepared in consultation with residents and was available for review.

Registration Regulation 4: Application for registration or renewal of registration

The provider submitted an application for renewal of registration to the office of the Chief Inspector in accordance with the registration regulations. Application fees were paid and the prescribed documentation was submitted.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was full time in post since 2019. They had the necessary experience and qualifications as required in the regulations.

Judgment: Compliant

Regulation 15: Staffing

From a review of rosters and the observations of the inspector, there was more than an appropriate number and skill mix of staff available to meet the assessed needs of the 28 residents living in the centre. From a review of rosters it was evident that there were 17.6 Whole time equivalent (WTE) registered nurses and 14.2 WTE care and multi-task attendant staff available. This is a significant increase from the statement of purpose against which the centre was registered, whereby 13 WTE nurses and 15 WTE care and multi-task attendant staff was outlined.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector found that staff training was not appropriate in relation to care planning and the requirement to notify incidents as evidenced by the following;

- there was a lack of staff knowledge with regard to the care planning process, as residents' care plans were not maintained in line with regulations and did not have enough detail to direct care as outlined under regulation 5.
- Staff were not aware of the requirement to notify incidents such as pressure ulcers, which were not recorded or notified in line with regulatory requirements.

Judgment: Substantially compliant

Regulation 23: Governance and management

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

- The system and oversight of training required action in relation to care planning and staff reporting of incidents such as pressure ulcers in the centre, as detailed under Regulation 16 Training and staff development.

- The system of audit and review required action as while there was an audit schedule in place, good compliance with audit findings was not reflected in the inspection findings as outlined under Regulation 5; Individual assessment and care plan.
- The system of oversight of incidents was not sufficiently robust. The inspector found that pressure ulcers were not being reported to the management team nor submitted to the Chief Inspector as required under Regulation 31 Notification of incidents.
- The system of oversight of complaints management required action as while complaints were logged, written responses were not provided to the complainant nor were records maintained to indicate that complaints were appropriately investigated as outlined under Regulation 31 Complaints procedure.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was amended on the day of the inspection with regard to the governance structure of the registered provider.

Judgment: Compliant

Regulation 31: Notification of incidents

From a review of a sample of five residents' records, maintained in the centre, the inspectors found that not all notifications had been submitted to the office of the Chief Inspector as evidenced by the following;

Two pressure ulcers were not recorded or notified in the quarterly reports as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

From a review of the records of complaints maintained in the centre, the inspector was not assured that complaints were investigated appropriately. Two complaints did not have records maintained of the outcome of the investigation. There was no evidence that written responses were provided to inform the complainant whether

the complaint was upheld, or of any improvements or learning arising from the complaints. This is a regulatory requirement and to ensure the service is improved from the complaints process.

Judgment: Not compliant

Quality and safety

Overall, residents living in Kenmare Community Nursing Home were supported to have a good quality of life, by a team of kind and caring staff. Residents had good access to healthcare services and opportunities for social engagement had improved since the previous inspection. However, action was required in relation to care planning as outlined further in this report.

The inspector found that residents had access to appropriate medical and allied health and social care professional support to meet their needs. A GP from a local practice attended the centre every weekday to review residents, and was onsite on the day of inspection. Residents had good access to speech and language therapy and dietitian services. From a review of residents' records, it was evident that validated assessment tools were used to develop care plans for residents. While these were used, care plans reviewed did not always reflect the current care needs of the resident and were not consistently updated following a change in a residents condition. These and other findings are detailed under Regulation 5; Individual assessment and care plan.

Food appeared nutritious and in sufficient quantities; drinks and snack rounds were observed morning and afternoon. It was evident to the inspector that there was close monitoring of residents' weights and nutritional assessments.

The premises was well maintained and provided residents with plenty communal areas to avail of, either in private, or in the company of others. The courtyard gardens were well maintained. Fire fighting equipment, emergency lighting and the fire detection and alarm system were all being serviced at the appropriate intervals. Annual certification was available to review. Staff spoken with, confirmed to inspectors, that they had received appropriate training and had completed drills to simulate the evacuation of residents. Staff were up-to-date with fire safety training. Two compartment fire doors required review and oxygen signage was missing from a room where a resident was using oxygen. This is detailed under Regulation 28; Fire precautions.

A record of restrictive practices in use in the centre was maintained and risk assessments were completed with regard to the usage of restraints such as bedrails. While, it was evident that some alternatives to bedrails such as low low beds and crash mats were in use, there was a high use of bedrails in the centre that required action as outlined under Regulation 7; Managing behaviour that is challenging.

Residents had access to an independent advocacy service and details regarding this service were advertised in the centre. There was evidence that advocacy services had been contacted by the management team to appropriately support residents. Residents' meetings were convened regularly to ensure residents had an opportunity to express their concerns or wishes.

Regulation 11: Visits

Visitors were welcomed in the centre and visitors confirmed that there were no restrictions on visits to the centre.

Judgment: Compliant

Regulation 13: End of life

From a review of a sample of care plans, it was evident that residents' care preferences for their end of life, were discussed with them and recorded. There was evidence of general practitioner and specialised palliative care services involved in residents' care at end of life. Residents' spiritual preferences were recorded. The unit had a designated palliative care rooms with facilities for family and visitors' use.

Judgment: Compliant

Regulation 17: Premises

The premises was well maintained and was designed to meet residents' individual and collective needs. Bedrooms were personalised and spacious and there was an ample number of communal spaces for residents' use.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents' hydration and nutrition needs were assessed, regularly monitored and met. There was plenty staff available at mealtimes to assist residents with their meals. Residents with assessed risk of dehydration, malnutrition or with swallowing difficulties had appropriate access to a dietitian and to speech and language therapy

specialists. Residents were offered a choice of meals and feedback from residents was positive regarding the choices and quality of food available to them.

Judgment: Compliant

Regulation 20: Information for residents

A residents information guide was available that included the complaint's procedure, the arrangements for visits and a summary of the services and facilities available in the centre.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

There was a system in place to ensure that relevant information about a resident was provided to the receiving hospital and was obtained from the discharging hospital as required, where a resident was temporarily absent from a designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

Action was required in relation to fire precautions as evidenced by the following.

- One compartment fire door was noted to have a gap when checked by the inspector and may not contain smoke effectively in the event of a fire.
- One set of fire doors were closing slowly and required review.
- A room where a resident was using oxygen did not have signage to indicate this so that staff would be aware in the event of a fire; this was actioned by the person in charge on the day of inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Significant action was required in respect of care planning arrangements for residents, to ensure that they were sufficiently detailed to guide practice and reviewed and updated when residents' condition changed. For example:

- A resident's care plan was not updated to reflect the changes in their condition on return from hospital
- A care plan did not reflect the recommendations of health and social care professionals following a swallow assessment
- Two care plans did not reflect residents skin condition or the presence and management of pressure ulcers and another regarding a skin tear, so that staff were aware of the wound care management plan.

These could lead to omissions or errors in care delivery.

Judgment: Not compliant

Regulation 6: Health care

The inspector found that residents had good access to medical services and a GP was onsite, on the day of inspection, reviewing residents. Health and social care practitioners such as physiotherapists, speech and language therapists, occupational therapists and dietitians reviewed residents as required. Residents had access to community palliative care specialists, when required. A speech and language therapist was onsite on the day of inspection supporting residents with communication difficulties with accessing communication aids and providing assessments for residents with swallowing difficulties.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspector identified that action was required to reduce the number of bedrails in use as restraint in the centre. The inspector saw that while some alternatives to bedrails such as crash mats and low low beds were used, bed rails were in use for over 40% of residents at the time of inspection, which was not in keeping with a restraint free environment.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents living in the centre had access to advocacy services as required. There was a schedule of activities available for residents that was supported by nursing and care staff, administrative staff and local volunteers. The centre maintained close links with the community and had regular visits from the local secondary students. Regular residents meetings were held to seek residents' views on the running of the centre. Residents had access to local and national newspapers, TV and radio.
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 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kenmare Community Nursing Unit OSV-0000753

Inspection ID: MON-0045960

Date of inspection: 06/03/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge has organized refresher training for the 16\04\2025 and the 24\04\2025 for all staff nurses focusing on the legislative and regulatory requirements of nursing documentation in care of the older person's services. • The Person in Charge has identified and allocated a "Documentation" lead and link person (CNM2 and senior enhanced Nurse) to guide, advise and assist nursing staff to enhance competencies in care planning in accordance with the NMBI code of conduct 2025.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge has organized refresher training for all staff nurses focusing on the legislative and regulatory requirements of nursing documentation in care of the older person's services on the 16\04\2025 and on the 24\04\2025. • The Person in Charge has reviewed the allocation of clinical auditing at ward level. Following this review, nursing documentation clinical audits will be undertaken by the CNM2 and Senior Staff Nurses going forward with monthly feedback to the Person in	

Charge who will follow up with the nursing team at ward level. In addition, clinical audit training has already been held on the 08\04\2025 to support the local assigned auditors to ensure non-compliances are actioned, monitored and resolved in a timely manner via the automated audit tool system. An external audit of the nursing documentation has been arranged and will be undertaken via the automated clinical audit system to establish a baseline standard at ward level which will inform the Person in Charge and CNM2/ documentation lead of areas that require additional support and focus by the nursing team.

The Person in Charge has submitted the two outstanding notifications identified by HIQA to the regulatory body on the 07\04\2025. The Person in Charge will ensure that all staff receive refresher guidance and direction on the critical importance of escalating critical incidents through line management. The Person in Charge will ensure that all staff are aware of the importance of using the "safety pause" at handover to communicate risks which has been updated to include any pressure sores identified.

• The Person in Charge acted in accordance with the HSE complaints policy and relevant legislation applicable to HSE facilities. The complaint was fully investigated by the Person in Charge and dealt with in accordance with the HSE complaints policy and requirements in S.I 652/2006. The complainant advised that they were fully satisfied with the manner and outcome of the investigation.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• The Person in Charge has submitted the outstanding notifications identified to the regulatory body on the 07\04\2025.
• The Person in Charge will ensure that all staff have received refresher guidance and direction on the critical importance of escalating critical incidences through line management. The Person in Charge will ensure that all staff are aware of the importance of using the "safety pause" at handover to communicate risks which has been updated to include any pressure sores identified.
• The Person in Charge will ensure that all notifications will be recorded and submitted to the office of the Chief Inspector as per regulation 31.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

• All complaints, however communicated to the Person in Charge/Complaints Officer, are entered into the Complaints Log. Working in accordance with policy and relevant regulations as outlined above, the investigation of all these complaints is seen as an important learning opportunity for staff. Wherever the need for improved practices and appropriate training and development for staff is identified, this is always detailed in the relevant complaints log entry.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• The Person in Charge has ensured that signage on the Residents door to indicate that Resident is using oxygen was erected on the 06\03\25.
• The Person in Charge has ensured that the fire doors were reported to maintenance on the 06/03/2025, same were reviewed and adjusted and seals replaced on the 11/03/025.

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 Person in Charge has organized training for the 16\04\2025 and the 24\04\2025 for all staff nurses focusing on the legislative and regulatory requirements of nursing documentation in care of the older person's services.

• The Person in Charge has identified and allocated a "Documentation" lead and link person (CNM2 and senior enhanced Nurse) to guide, advise and assist nursing staff to enhance competencies in care planning in accordance with the NMBI code of conduct 2025.

• The Person in Charge has reviewed the allocation of clinical auditing at ward level, nursing documentation clinical audits will be undertaken by the CNM2 and Senior staff Nurse going forward with monthly feedback to the Person in Charge and the nursing

team at ward level. In addition, clinical audit training has been held on the 08\04\2025 to support the local auditors on ensuring non-compliances are actioned, monitored and resolved in a timely manner via the automated audit tool system.

• An external review of the nursing documentation has been arranged and will be undertaken via the automated clinical audit system to establish a baseline at ward level and inform the Person in Charge and CNM2/ documentation lead of areas that require additional support and focus by the nursing team.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• The Person in Charge ensures Kenmare CNU promotes a restraint free environment. All residents admitted to Kenmare CNU are assessed by nursing staff using a collaborative consultative bedrail risk assessment tool. The bedrail risk assessment tool is based on the national restraint policy.
• Alternatives to bedrails are promoted and applied in accordance with the national restraint policy and the bedrail risk assessment tool. Where bedrails are applied, an appropriate risk assessment and care plan are in place in accordance with the national restraint policy. The application of bedrails is based on this assessment and evaluation.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	24/04/2025
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	17/04/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	11/03/2025

Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	07/03/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	31/03/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a	Not Compliant	Orange	31/03/2025

	resident's individual care plan.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/04/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/04/2025