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:	Cashel Residential Older Persons Services
Name of provider:	Health Service Executive
Address of centre:	Our Lady's Campus, The Green, Cashel, Tipperary
Type of inspection:	Unannounced
Date of inspection:	22 May 2025
Centre ID:	OSV-0007812
Fieldwork ID:	MON-0046525

About the designated centre

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

Cashel Residential Older Persons Service is a new centre operated by the Health Service Executive (HSE) set in the grounds of our Lady's hospital Cashel. It is set out over three floors and consists of three units providing a total of 60 beds. One of the units St Clare's is a stand alone unit for 11 female residents and specializes in dementia care. The other two units are in the main building in Our Lady's hospital one on the first floor which can accommodate 29 residents and one on the second floor that can accommodate 20 residents. The bedroom accommodation is provided in a mixture of single bedrooms, two rooms, three bedded rooms and one four bedded room. The majority of the bedrooms contained full en-suite bathrooms and additional shower rooms and toilets were located in close proximity to bedrooms. The communal space included a number of sitting rooms and dining rooms in each of the units and additional multipurpose rooms including a large sitting/activity room and an oratory were located on the ground floor. A large enclosed garden area was available at the front of the building that provided walkways and seating for residents and a smaller rooftop garden was available on the second floor. St Clare's unit have their own separate, well-maintained and enclosed garden. Cashel Residential older persons service provides 24 hour nursing care for female and male residents. It provides for residents of all dependencies from low to maximum. There is a good ratio of nurses on duty during the day and at night time. The nurses are supported by care, catering, household and activity staff. Medical and allied healthcare professionals provide ongoing healthcare for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	60

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	09:40hrs to 18:15hrs	Mary Veale	Lead
Thursday 22 May 2025	09:40hrs to 18:15hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day by two inspectors. Over the course of the inspection, the inspectors spoke with eight residents, seven visitors and staff to gain insight into the residents' lived experience in the centre. All residents spoken with were overwhelmingly complimentary in their feedback and expressed satisfaction about the standard of care provided. The inspectors spent time in the centre observing the environment, interactions between residents and staff, and reviewed various documentation. Residents spoke of exercising choice and control over their day and being satisfied with activities available. Residents' told inspectors that they said that they could approach any member of staff if they had any issue or problem to be solved.

Cashel Residential Older Persons Services is situated on the grounds of Our Lady's Hospital campus in the town of Cashel, Co.Tipperary. There were 60 residents living in the centre on the day of inspection. The centre comprised of two buildings. The main campus was a three storey building. Tir na Óg unit was on the first floor and Croí Óir unit was on the second floor. St Clare's unit was a stand alone unit providing care for residents with dementia.

There was a choice of communal spaces in the main campus, and St Clare's unit which were seen to be used thought out the day by residents. For example; the main campus had two day rooms on the first and second floors, two dining rooms on the first floor, and an oratory on the ground floor. St Clare's unit had two large bright day room spaces.

Bedrooms comprised of single, twin bedded, three bedded and four bedded bedrooms, some with en-suite facilities and others with shared toilet facilities. Residents' bedrooms were clean, suitably styled with adequate space to store personal belongings. The majority of residents had personalised their bedrooms with photographs, ornaments and other personal memorabilia. The privacy and dignity of the resident's accommodation in the shared bedrooms was protected, with adequate space for each resident to carry out activities in private and to store their personal belongings. However; further improvements were required to enhance the residents privacy from the corridor area. This is discussed further in this report under Regulation 9: Residents rights.

Residents were observed to have access to outdoor spaces on the day of inspection. The main campus had a large enclosed garden area at the front of the building which was easily accessible. The large garden had level walkways, a pergola, a large wall mural, and seating for residents. Croí Óir unit had a small roof top garden overlooking the Rock of Cashel. There were three rooms with a balcony area on Tír na Óg unit. St Clare's unit had an attractive, enclosed garden space. There were designated outdoor smoking areas. Two balcony areas which were accessible through bedrooms on the Tír na Óg unit were designated smoking areas.

On the day of inspection the inspectors observed that the purpose of some of the bathrooms had been changed. These changes are discussed under Regulation 23: Governance and management.

The inspectors observed that the call-bell system on Croí Ór unit was not making an alarm sound but had a call-light. Assurances were received on the day of inspection that a procedure was in place to ensure staff were monitoring the call-light system to ensure call-bells were answered promptly. On the evening of the inspection the passenger lift in the centre broke down and was not operational. Alternative arrangements were but in place for a resident who had just returned to the main campus to go to a communal area in St Clares Unit while waiting for the lift to be operational. Assurances were received that the passenger lift was operational later that evening.

As the inspectors walked through the centre, residents were observed to be content as they went about their daily lives. Residents sat together in the communal rooms chatting, participating in arranged activities, or simply relaxing. Other residents were observed sitting quietly, observing their surroundings. Residents were relaxed and familiar with one another and their environment, and were observed to be socially engaged with each other and staff. A small number of residents were observed enjoying quiet time in their bedrooms. It was evident that residents' choices and preferences in their daily routines were respected.

The inspectors chatted with a number of residents about life in the centre. Residents spoke positively about their experience of living in the centre. Residents commented that they were very well cared for, comfortable and happy living in the centre. Residents said that they felt safe, and that they could speak with staff if they had any concerns or worries. There were a number of residents who were not able to give their views of the centre. However, these residents were observed to be content and comfortable in their surroundings.

A range of recreational activities were available to residents, which included exercise, movies, knitting, music and bingo. The centre employed activities staff who facilitated group and one-to-one activities throughout the day. Residents told the inspectors that they were free to choose whether or not they participated. On the day of the inspection, the inspectors observed residents enjoying bingo. Residents told the inspectors that they enjoyed recent day trips to Ardfinnan, Carrick-on-Suir, Clonmel, Dungarvan and Holy Cross abbey. Residents had access to television, radio, newspapers and books. Although residents were satisfied with the activities provided, further action was required to ensure residents had access to the internet. This is discussed in this report under Regulation 9: Residents rights.

The inspectors observed the evening time meal experience and found that the meals provided appeared appetising and served hot. Residents were complimentary about the food and confirmed that they were always afforded choice and provided with an alternative meal should they not like what was on the menu. Adequate numbers of staff were available and were observed offering encouragement and assistance to residents.

Residents said that their clothes were regularly laundered and returned to their rooms and that they did not have any complaints about the laundry service. The centre had contracted the residents' laundry, bed linen and towels laundry service to a private provider.

Residents' views and opinions were sought through regular resident committee meetings. Residents said that they felt they could approach any member of staff if they had any issue or problem to be solved.

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

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). This inspection also had a specific focus on the provider's compliance with fire safety oversight, practices and processes.

Overall improvements were required in the management of the service to ensure safe effective systems were in place to support and facilitate the residents to have a good quality of life. Following this inspection an urgent compliance plan was issued to the registered provider requesting assurances to mitigate the risks associated with the residents assessment needs for evacuation and vertical mode of evacuation to ensure residents could be evacuated safely.

The inspectors found that the compliance plan following the previous inspection of January 2024 had not been progressed and repeated findings of non-compliance's were found in care planning, access to healthcare, the premises, governance and management, and fire safety on this inspection. Further improvements were required to ensure medications were stored safely.

The registered provider is the Health Service Executive (HSE). There was a management structure with identified lines of accountability and responsibility for this service. The person in charge (PIC) had sole responsibility for this centre and was supported in her role by clinical nurse managers (CNM's), nursing staff, health care assistants, activity staff, kitchen staff, housekeeping, and administration staff. The manager of the service, who was the registered provider representative also provided support to the PIC. The PIC was supported by the director of nursing (DON) who was a person participating in management (PPIM) who had oversight responsibility for this centre, a rehabilitation unit in Cashel and another residential care unit in Clonmel.

There were sufficient staff were on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a well-established staff team who

were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

There was an ongoing schedule of training in the centre and the person in charge had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and the inspectors noted that training was up to date. Staff with whom the inspectors spoke with, were knowledgeable regarding safeguarding and infection prevention and control procedures. However; further improvements were required in the supervision of staff in relation to fire safety training, this is discussed further in this report under Regulation 28: Fire precautions.

The inspectors viewed records of governance meetings, and staff meetings which had taken place since the previous inspection. Governance meetings and staff meetings took place quarterly in the centre. The person in charge and director of nursing discussed key performance indicators (KPI) with the manager for older persons at governance meetings. There was evidence of trending of incidents, infections and antibiotic use which identified contributing factors such as the location of falls and times of falls, and types of infections and recurrence. Since the previous inspection, falls audits, care planning audits, medication audits, infection prevention control audits, antibiotic use audits and fire safety audits had been completed. A detailed annual review for 2024 was available, it outlined the improvements completed in 2024 and improvement plans for 2025. A review of the centres audit system was required this is discussed further under Regulation 23: Governance and Management.

Manual records viewed on inspection were well-presented and organised which supported effective care and management systems in the centre. The inspectors reviewed staff files which contained all the requirements under Schedule 2 of the regulations. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available for each member of staff in the designated centre.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes. The inspectors followed up on incidents that were notified since the previous inspection and found these were managed in accordance with the centre's policies.

The inspectors reviewed the records of complaints raised by residents and relatives and found they were appropriately managed in line with the HSE complaints process "Your service Your say". Residents who spoke with the inspectors were aware of how to make a complaint and to whom a complaint could be made.

Regulation 15: Staffing

On the inspection day, staffing was found to be sufficient to meet the residents' needs. There was a minimum of five registered nurse on duty at all times for the

number of residents living in the centre at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safe guarding, managing behaviours that are challenging and, infection prevention and control. While all staff had completed fire safety training; further action was required to include vertical evacuation to the fire safety training programme. This is discuss under Regulation 28: Fire precautions.

Judgment: Compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to the inspector. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

The overall governance and management of the centre was not effective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example:

- The centres audit system and processes required review. For example: High levels of compliance had been achieved in recent audits such as care planning, fire safety and medication management audits. This did not reflect in the findings on this inspection.
- Fire safety management within the centre required review. For example: oversight of the various evacuation strategies was not adequate. Although identified previously by the provider, no action was taken to address the risk where staff had not received training in, or participated in drills for, vertical evacuation. This is a repeated finding of non-compliance on inspection in January 2023. The provider had provided fire and evacuation training for staff, however, training did not included vertical evacuation training for staff.
- Oversight if care plans required improvement as outlined under regulation 5.

This is a repeated finding of inspection.
- Oversight of premises required improvement as outlined under regulation 17.

Changes made to the premises were not in line with the statement of purpose, which the Health Service Executive was registered against and had not been communicated to the Office of the Chief Inspector. For example:

- The bath had been removed from the bathroom on Tír Na Nóg unit, and the room was observed as a store room on the inspection day.
- The bath had been removed from the bathroom on St Clares unit, and the room was observed as a store room on the inspection day.
- The Laundrette room on St Clares unit was observed as a store room on the inspection day.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the registered provider of the centre. These clearly outlined the room the resident occupied and additional charges, if any.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the office of the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider provided an accessible and effective procedure for dealing with complaints, which included a review process. The required time lines for the investigation into, and review of complaints was specified in the procedure. The procedure was prominently displayed in the centre. The complaints procedure also provided details of the nominated complaints and review officer. These nominated

persons had received suitable training to deal with complaints. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the provider was, in general, delivering a good standard of nursing care; however, the gaps in oversight, as mentioned in the Capacity and Capability section, impacted on the quality and safety of residents living in the centre. The findings of this inspection are that further action was required to come into compliance with care planning, access to healthcare, residents rights, premises, fire safety and medication management.

The inspectors viewed a sample of residents' nursing notes and care plans. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet their needs. Care planning documentation was available for each resident in the centre. However, a review of a sample of care plans found that there was insufficient information recorded to effectively guide and direct the care of these residents. Details of issues identified are set out under Regulation 5.

Residents had timely access to a medical officer, health and social care professionals, such as psychiatry of old age, physiotherapy, and speech and language, as required. Residents had access to a mobile x-ray service referred by the medical officer which reduced the need for trips to hospital. Residents had access to nurse specialist services such as community mental health nurses, specialist nurse, and tissue viability nurses. Residents had access to local dental and a local pharmacy service. Residents who were eligible for national screening programmes were also supported and encouraged to access these. However; residents did not have access to a dietitian since 2024. The person in charge informed the inspectors that there was no private provider or agency services who could provide a dietitian service to the residents

A HSE national safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. All interactions by staff with residents were observed to be respectful throughout the inspection. Residents reported that they felt safe living in the centre. The centre acted as a pension agent for a small number of the residents. There were robust accounting arrangements in place and monthly statements were furnished.

There were staff assigned to the provision of social activities in the centre.

Arrangements were in place for consulting with residents in relation to the day to day operation of the centre. Resident feedback was sought in areas such as activities, meals and mealtimes and care provision. Records showed that items raised at resident meetings were addressed by the management team. Information regarding advocacy services were displayed in the centre. Notwithstanding these good practices, further improvements were required to the residents choice to undertake activities in private which is discussed further under Regulation 9: Residents rights.

There was good oversight of infection prevention and control (IPC) in the centre. There was an IPC policy available for staff which included COVID 19 and multi-drug resistant organism (MDRO) infections. Staff were observed to have good hygiene practices and correct use of PPE. The centre had contracted its bed linen laundry and resident's laundry to a private provider. There was evidence that infection prevention control was an agenda item on the minutes of the centres staff meetings. IPC audits included, the environment, PPE, antibiotic usage and hand hygiene were evident. A number of the nursing staff had undertaking infection prevention and control link nurse training. There was a low level of prophylactic antibiotic use within the centre, which is good practice.

As the centre was within two separate buildings, the evacuation strategy was different in each. In Clare's Unit, ski sheets under the mattress or wheelchairs were identified as the mode of evacuation for residents reduced mobility, depending if the resident was up or they were in their bed. The staff had practiced drills. In the three storey building, all resident accommodation was on the first and second floor. Given the width of the bedroom doors, bed evacuation was used to evacuate horizontally to the next compartment; the strategy stopped at horizontal evacuation and vertical evacuation was not part of the strategy, or training for staff. Assurance was required from the provider that staff could safely evacuate residents from the upper floors.

Fire containment overall was in place; fire compartments were confirmed to the inspectors and there was evidence from contractors labels that fire sealing had taken place to maintain fire containment. However, the inspector observed deficits to fire doors and some rooms where the door was not appropriately fire rated.

Not all doors on the escape corridors were fire compartment doors (a door through which residents are assisted to escape to a relative place of safety). The provider had a system where fire compartment doors were painted a specific colour. The doors at first floor followed this arrangement, however the doors at second floor had been painted another colour.

Actions required relating to fire safety are explored in more detail under regulation 28: Fire Precautions

On the day of inspection, the lift in the main building stopped working, which meant that residents were unable to leave or return to the upper floor. The person in charge responded immediately and arranged for a lift technician to attend site that evening. Furthermore, the call bell at second floor was not functioning correctly since the previous day; the light would operate but the audible element of the

system was not working. The person in charge confirmed this would be managed with arrangements in place for staff to increase monitoring and also by ensuring a staff member was on the corridor at all times, including night time to ensure call bell alerts would be responded to.

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving. Further improvements were required in the storage of medications, this is discussed further under Regulation 29: Medicines and pharmaceutical services.

Regulation 17: Premises

Action was required by the provider to ensure compliance with regulation 17 and schedule 6;

- The visitor's room at first floor did not have a call bell as required in Schedule 6.
- A call bell in a shower room was too high and out of easy reach.
- The Oratory in St. Clare's was being used for storage of a mattress and previous resident's belongings and was not usable by residents.
- Aspects of St Clare's were not sufficiently maintained internally and some areas required repair. For example; the door to a store room was badly damaged, the flooring in a store room was lifting, the call bell in the smoking area in Clare's unit required repair and there was a loose light fitting in the rear corridor. There was a load noise from the light in the chemical store and it was not working.
- The sinks in residents' en suites did not have a means to retain water in the sink if a resident wished to use this for personal hygiene.
- In some single rooms, that did not have an ensuite there was a clinical hand wash sink only. This meant that the resident did not have a sink for personal hygiene use and was required to use a sink in a communal bathroom off the corridor.
- There were broken beds and privacy screens being stored externally in a covered area awaiting to be disposed of.
- The waste store room in Tir na Nog unit was not ventilated.
- There was a leak in the ceiling within a nurse office which required repair.
- In one bedroom, the wall was damaged from a metal bin, resulting in exposed plaster.
- The water in the hot tap in a day room in Croi Oir was too hot and did not have a thermostatic control valve to control the temperature of the water.
- The lock to the coded gate to the secure garden did not engage when the gate swung to the closed position.

Some areas of the floor plans were not a correct reflection of the layout and required amendment, for example;

- The lobby between the kitchen and the main stairs was not in place.
- A cleaners store was being used as a kitchen store.
- The external storage sheds by St. Clare's Unit was not marked in red
- The changes made to the centre as detailed in regulation 23 above.

Judgment: Not compliant

Regulation 27: Infection control

The centre was very clean and there was adequate cleaning staff employed. Staff were observed to be adhering to good hand hygiene techniques. There were sluicing facility on the premises which were clean and well maintained. Housekeeping staff were knowledgeable about cleaning practices, processes and chemical use. Hand washing facilities were available for staff on each of the units. Infection prevention and control training was up to-date.

Judgment: Compliant

Regulation 28: Fire precautions

The inspectors were not assured that the registered provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire. The provider had not made adequate arrangements to safely evacuate all residents from the upper floors, nor were staff trained in the technique of vertical evacuation. The assessed evacuation needs of residents were not being updated. An urgent compliance plan was issued and the provider's response did provide assurance that the risk was adequately addressed. The provider provided assurance that vertical evacuation training would commence within a short time frame and that all Personal Emergency Evacuation Plans (Peep) had been reviewed and updated.

The provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions, for example:

- When the kitchen was finished for the day and staff had left, the inspectors observed the pilot light in the gas cooker left on. The person in charge switched it off.
- The inspectors observed fire doors in St. Clare's Unit propped open in the household store and the chemical store.
  Storage was observed in the Comms switch room and the door was not kept locked. The director of nursing arranged for the storage to be removed

during the inspection.
- A large oxygen cylinder was stored adjacent to combustible materials in the treatment room.

The arrangements in place for maintaining fire equipment, means of escape, building fabric and building services were not adequate, for example;

- Deficits to fire doors required action to ensure they would contain the spread of fire and smoke. The inspectors observed gaps, missing smoke and heat seals, absent door closers and a door getting caught on floor covering. The provider is required to review all fire doors to ensure they are functioning and effective to appropriately contain the spread of fire and smoke where required.
- A recent quarterly report for the emergency lighting identified repairs were required to the system and there was no evidence to show this was complete. The annual confirmation of service and testing had been also withheld owing to some deficits.

The provider was not ensuring an adequate means of escape was provided, including emergency lighting, for example:

- The main kitchen was accessed directly onto the main escape stairway; this did not align with the registered floor plans which showed a lobby between the kitchen and the stairway. Assurance was required by provider as to how they protected the escape stairs from the risk of fire in the kitchen.
- The landing at the top of an external stairway was being used as a small outdoor terrace for residents to smoke. At the top of the stairs there was a bespoke gate, operated by a weighted pulley to open the gate. The inspectors were told this was connected to the fire detection and alarm system and would open if the fire alarm activated. The door from the corridor leading to this escape stairs was narrow, with a wider door directly from the adjacent residents bedroom. This full arrangement requires review by the provider's competent person to ensure an adequate means of escape from this area, including the use of the landing area and the bespoke gate system.
- The terrace at second floor also provided a means of escape and required a timber gate to open. This was reported to inspectors that it released on activation of the fire alarm. Assurance was required if the gate released by activating a green break glass unit.
  There was a change in level between the bedroom corridor and the access to the second floor terrace. There was a steel ramp and landing on the corridor to facilitate circulation to the terrace and for means of escape. However, in order to assist resident from the bedroom across the corridor, staff were required to slide the ramp down the corridor, and then return it if these resident were being assisted through the terrace escape route. This arrangement also required review by the provider's competent person.
- In Clare's Unit; the external escape route to the rear required review. All exits led to the rear path which meant that if a fire was in the room opening on to the path, there was no option but to escape past the window. Furthermore, there was one gate which was mechanically operated and the inspectors

noted that it did not stop if pressure applied, creating a risk of injury if it closed if someone was going through the gate.
- External escape routes in some areas did not have appropriate signage and marking to prevent cars and delivery vans from obstructing escape routes. The inspectors observed a van parked obstructing an external stairway.
- In Clare's Unit, an exit sign led into an area being used a staff changing room, which also had an exit directly to the outside. The provider is required to review the approved design of the means of escape to determine if this route was a designated escape route.
- The exit signage required review in a number of areas. The inspectors noted some areas where exit signage was not visible and as referenced above, one led from a corridor through a staff changing room.

Action was required to ensure adequate containment and detection of fire, for example;

- Doors to some risk rooms in Clare's unit, opening onto the central corridor dining area, were not fire doors, for example the treatment room, a linen store.
- Rooms previously used as bathrooms were being used for storage and were not fitted with a fire door to contain fire.

The registered provider had not made adequate arrangements for staff of the designated centre to receive suitable fire safety training, for example;

- A shortfall in the fire safety training for vertical evacuation created a risk to the safety of residents on the upper floors of this centre.
- Fire safety training rotates between online training and in person training every two years. This did not align with the centres policy which indicated that staff must participate in fire safety training and evacuation drills annually.

The measures in place to safely evacuate residents and the drill practices in the centre required action

- As vertical evacuation had not been part of the fire drill programme, assurance is required that any and all evacuation aids in use fit along and from the escape stairs.
- Drill records reviewed did not have sufficient detail to demonstrate if the evacuation strategy was fit for purpose. It could not be determined if a drill simulating the largest compartment of eleven residents had been practiced, nor did it indicate if they simulated lowest staffing levels.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Further action was required to ensure residents were protected by safe practices in respect of storing medication as follows:

- One of the medication trolleys in the clean utility room on St Clares unit was not lockable. The door to the clean utility room had a digi-lock and the code to enter the room was written on the outside of the door.
- A box of analgesia was left on the top one of the medication trolleys on St Clares unit.

Medications not stored securely has the potential to be accidentally ingested by a resident or stolen.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A number of resident plans did not contain the necessary information to guide effective care delivery. For example:

- A resident who had a fall did not have their care plan updated following the fall.
- A care plan was not developed for a resident who had shoulder pain.
- A care plan was not developed for a resident who had an infection of their eye
- There were disparities found in a skin care plan for a resident and the residents skin care regime documented in the progress notes.
- Care plans viewed required review to ensure a person-centred approach to care was provided. A sample of care plans viewed were not sufficiently detailed or person centred to guide staff on the care of residents. Care plans were generic with pre-populated interventions. This was a repeated finding on previous inspections.

From a review of PEEP documents, they were not being reviewed or audited to ensure they were up to date. The detail contained in the PEEP referenced ski sheet or wheelchair evacuation; they did not reflect bed evacuation.

Judgment: Not compliant

Regulation 6: Health care

The registered provider did not ensure that all resident had appropriate access to health care expertise. For example; residents did not have access to a dietitian. The impact of residents not having access to a dietitian could put the residents at a higher risk of malnutrition, which can lead to a cascade of negative health

outcomes, including increased frailty and falls, and poor wound healing.

Judgment: Substantially compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' right to privacy and dignity was not always upheld by the registered provider. For example;

- The inspectors observed on the day of inspection that curtains were not drawn around a resident who was in a state of undress and could be seen through a vision panel window on the bedroom door. This impacted on the privacy and dignity of the resident.
- The Oratory in St. Clare's unit was being used for storage of a mattress and previous resident's belongings and was not usable by residents to exercise their religious rights.

Inspectors were informed by the person in charge that the registered provider had given a commitment to install Wifi boosters in the centre so as to enhance the Wifi signal in the centre. On the day of inspection a resident told the inspectors that they had Wifi coverage on their mobile phone but that there was certain parts of the centre where there was no Wifi coverage. This impacted on the residents ability to communicate with family or friends.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cashel Residential Older Persons Services OSV-0007812

Inspection ID: MON-0046525

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**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Review of current Audit system in relation to Care Planning, Fire Safety and Medication Management. Review and amend audits to capture specific findings on this Inspection relating to above Categories. Meeting held with Quality/Risk Advisor on the 9/07/2025 in relation to the above – review undertaken and actions agreed and completion by 31/07/2025. Specific Evacuation Training commenced on May 24th with further date's scheduled for ongoing training throughout 2025. Targeted completion of training for all staff by 31/08/2025. • Changes to Premises: Baths /sanitary units to be reinstalled in both Tir na nog and St Clare's units as per original SOP. Expected completed completion September 2025. • The Cleaners Room is now reverted to its original and specific function and is no longer used for kitchen supplies. Completed on 17/06/2025 • The Laundrette room on St Clare's unit has now returned to its original function Completed on 17/06/2025	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The visitor's room at first floor now has a call bell as required in Schedule 6. Completed on 27/05/2025 by Technical Services Department	

• A call bell in a shower room was reinstalled and is correct length from floor Completed on 26/05/2025 HSE Maintainence dept

• Review of St Clare's Unit in relation to maintenance and repair i.e. flooring/painting of areas. Approved and planned completion by 18/08/2025

• Call bell in the smoking area in Clare's unit now working – Completed 25/05/2025

• .Light in the chemical store now working - completed on the 25/05/2025.

• The sinks in residents' en suites have been upgraded to retain water in the sinks. completed by Technical services 20th of July 2025.

• Review of sinks in all single rooms /ensuites so that Residents can use for own personal use by Technical Services on 20/08/2025.

• Technical Services removed broken beds and privacy screens being stored externally in a covered area with immediate effect on the 30/05/2025. Completed

• An electronic vent and system to be installed in Tir na Nog Waste Management Room by Technical services. To be completed by 25/07/2025

• Leak in ceiling of Nursing Station to be repaired and repair of the bedroom wall to be reviewed by Technical Services. To be completed by 25/07/2025

• Installation of thermostatic control valve to control the temperature of the water for hot tap in Day Room of Croi Oir. To be completed by 25/07/2025.
• Floor Plans to be reviewed and amended, lobby removed between kitchen /main stairs, storage shed at back of St Clare's to be highlighted in red by Estates Department. Currently filed with our Estates department for updating & once completed will be submitted to the Inspector. – Awaiting update

• Kitchen supplies removed with immediate effect so that its purpose is a Cleaners Store - Completed

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Vertical Evacuation Training ongoing.
40 Staff completed training between the 28/05/2025 & the 18/07/2025 with further dates booked 13/08/25, 27/08/25 & 10/09/25. Two staff members to complete

instructor training in August 2025 to become trainers for vertical evacuation. These training dates have been booked and confirmed.
Review of all Residents Peep Form completed and updated 30/05/2025
Pilot Light to remain continuously off, all Kitchen Staff informed of new practice - completed 22/05/2025.

• Removal of all props to keep Fire Doors open with immediate effect on day of Inspection completed 22/05/2025
• Call Bell on Second Floor repaired - completed 26/05/2025
• Storage removed with immediate effect from COMMS Switch room - completed 22/05/2025
• Oxygen Cylinder removed. Completed22/05/2025

• The current training provider will be requested to facilitate, demonstrate and record the evacuation strategy with reduced staffing levels in St Clare's largest compartment.

• A private provider has been requested to carry out further inspection of all Fire Doors, and furnish a report which is expected in August 2025.

• A private provider are certifier for service and testing all FDAS and emergency lighting systems, all documents have being submitted and reports are available in cabinet beside Fire Alarm Panel.

• The bespoke gate system was challenged and tested during a Fire Drill carried out 10/06/2025. On activation of Alarm all components worked and door opened. A programme of works has commenced to remove the non-compliant narrow door and to create space and add an additional complaint fire escape door, thus providing adequate space and use of the door adjacent to the resident's room. The current exit door will be removed and the size of the escape route will be increased. – Works commencing 06/08/2025 with expected completion in October 2025.
• The bespoke fire alarm system on the Terrace on the 2nd floor was tested on 10/06/2025 by the HSE Fire Officer & found to be in full working order, the door opening mechanism was tested and found to open as required. - Completed

• The steel ramp on Croi Oir will be removed and a fixed ramp leading to a compliant exit door will be installed by 30/10/2025 by Technical Services.

• In St Clare's unit-, The mechanically operated emergency exit gate direction opening will be reviewed by Technical Services Department and the safety systems are to be reinstated. New automated system ordered, and expected to be installed by 31/08/2025.

• There is now a designated means of escape whereby the Changing Room has been relocated post inspection on St Clare's Unit 20/06/2025 by Maintenance Dept – Completed

• Exit Signage reviewed by Technical Services with additional signage to be added to Our Lady's Campus by 30/10/2025. External escape routes are to be clearly identified by hatch markings and patrons in these escape routes to be protected by 30/10/2025.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• Unlockable Medication Trolley removed and to be replaced - order submitted in May for new Medication Trolley expected delivery 6 to 8 weeks. Approx. August 2025

• All codes written above digital locks in St. Clare's removed 22/05/2025. Completed

• Container of Analgesia removed from top of Medication Trolley - Completed 22/05/2025

• All Nursing Staff to update training HSE land - Medication Management to be completed by 24/07/2025

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:

• Care plan updated on Resident in relation to Fall, Shoulder pain, infection in eye, skin care completed on 30/05/2025.

• Care Plan Training updated with designated sessions to be held over two month period by designated trainers to ensure a person centered approach to care is being provided, Scheduled to commence September 2025

• Director of Nursing to provide Feedback Meeting with Staff Nurses at monthly scheduled Meetings to discuss non-compliance in relation to Care Planning, following training in September 2025.

• Care Planning to be entered and escalated to CROPS Risk Register and discussed with QPS advisor 30/07/2025.

• Peeps Reviewed and are now part of quarterly review of Documentation with introduction of same 22/07/2025

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Sourcing of Agency Dietician within the Agency Framework has been explored

Dietetic post will be considered as part of the overall recruitment process and with consideration for overall WTE ceilings at the Employment Control Forum.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Installation of Blinds/Tinting/Window Film in the Vison Panel Window on the Residents Bedroom Doors – to be completed by 31/08/2025

• Removal of all belongings / Mattresses with immediate effect in St Clare's Unit Completed on 22/05/2025 by Maintenance Staff

• Awaiting survey completion by a private provider for installation of Wi-Fi and roll out of introduction of Wifi over six months commencing 15/09/2025 – Currently awaiting update of HSE National Wifi rollout plan.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/10/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/08/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Not Compliant	Orange	31/07/2025

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/10/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/07/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	10/08/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the	Not Compliant	Orange	30/10/2025

	procedures to be followed should the clothes of a resident catch fire.			
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.	Not Compliant	Orange	10/08/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	10/08/2025
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 and safe placement of residents.	Not Compliant	Red	27/05/2025
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the	Substantially Compliant	Yellow	25/08/2025

	centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/09/2025
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	25/07/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	15/10/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	03/12/2025

Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	03/12/2025