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:	Firstcare Blainroe Lodge
Name of provider:	Firstcare Blainroe Lodge Limited
Address of centre:	Coast Road, Blainroe, Wicklow, Wicklow
Type of inspection:	Unannounced
Date of inspection:	11 June 2025
Centre ID:	OSV-0000016
Fieldwork ID:	MON-0047409

About the designated centre

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

Firstcare Blainroe Lodge Nursing Home has four floors; a lower ground, ground, first and second floor. The centre can accommodate 72 residents. Residential accommodation is across the four floors which are accessed by a lift and stairs. Care can be provided for adults over the age of 18 years with general care needs within the low, medium, high and maximum categories. A pre-admission assessment is completed in order to determine whether or not the service can meet the potential resident's needs. Twenty-four-hour nursing care is provided. In total, there are 38 single rooms with full en-suite facilities, 25 single rooms with toilet and wash-hand basin and two additional single rooms with wash-hand basins. There are three twin rooms with toilet and wash-hand basin facilities. There were adequate communal areas and private areas for residents to receive visitors. Other areas include a kitchen, laundry, oratory, hairdressing salon, smoking room and activities room. There are several well-maintained enclosed garden areas for residents' use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

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
Wednesday 11 June 2025	16:50hrs to 21:30hrs	Ella Ferriter	Lead
Thursday 12 June 2025	09:00hrs to 16:30hrs	Ella Ferriter	Lead
Wednesday 11 June 2025	16:50hrs to 21:30hrs	Caroline Connelly	Support
Thursday 12 June 2025	09:00hrs to 16:30hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection which was carried out over one evening and one day. Two inspectors spent time over the two days observing care practices and staff interactions with residents, as well as speaking to residents, staff and visitors. Overall, 12 residents spoken with told inspectors that they were happy and satisfied with their life in the centre, telling inspectors that staff were kind, very good to them and they worked hard. However, some residents told the inspectors that staff were very busy and may be delayed in answering bells and providing assistance. A large proportion of residents living in the centre had a diagnosis of a cognitive impairment and could not converse with the inspectors. The inspectors met with ten visitors over the two days. The majority of feedback from visitors was positive about the care their family member received and the fact they could visit at any time. However, some visitors told inspectors that due to staffing shortages, their family member did not always get appropriate timely care.

On arrival to the centre at 4.50 pm, on the first evening, the inspectors met with the management team and were accompanied on a walk around of the centre. Inspectors enquired as to the time of the evening meal and were informed that this was over, and had been served at 4pm. Inspectors enquired as to the reason for serving this meal early, however, there was no explanation or evidence of residents requesting this early time. Overall, on the first evening of this inspection it was observed that a large proportion of residents living in the centre were in bed or in their bedrooms. Some staff spoken with informed inspectors that a number of residents remained in bed, due to their risk of skin breakdown and to prevent pressure ulcers. Other staff stated that on some days they were too busy to assist residents to get up. Some relatives also informed inspectors that their relative was only assisted to get up every second or third day, due to insufficient numbers of staff on their unit. These findings are actioned under regulation 15; Staffing.

On the first evening of the inspection, inspectors saw that across three units only nine residents were still up and in the communal rooms watching television or chatting with each other. Two of these residents were preparing for a game of cards, which they informed inspectors they enjoy every evening with visitors. Inspectors saw that at 6:30pm residents received a cup of tea and a biscuit. Inspectors were not assured that this met residents' nutritional needs. Staff spoken with stated that there were also sandwiches available at this time, however, these were not seen to be served to residents. Inspectors also observed that there was not a sufficient supply of nutritional snacks in the refrigerators in each of the units, to ensure residents could have access to additional snacks if they were hungry. This was discussed with the management team at the time and they stated that staff could access the main kitchen on the lower ground floor, however, this meant that nutritious snacks were not easily accessible. This finding is actioned under Regulation 18; Food and Nutrition.

Firstcare Blainroe Lodge provides long term care for both male and female adults, with a range of dependencies and needs. The centre is situated on the coast road in Blainroe, County Wicklow. It is a four story premises which can accommodate 72 residents. There were 45 residents living in the centre at the time of this inspection. Bedroom accommodation is composed of 63 single and five twin rooms. The centre is divided into five distinct wings. Seafield and Brittas are situated on the ground floor, there is a dementia specific unit called Silverstrand on the first floor and Bayview is situated on the second floor. Inspectors noted that there were two residents living on Bayview at the time of this inspection and these residents were independent with their care needs. Bedrooms were seen to be personalised, and many had residents' names on the door and their life story hanging on their wardrobe depicting their family members, past profession and personal preferences. The lower ground floor named Bayside was unoccupied on the days of this inspection, as there were not measures in place to support the safe evacuation of residents from this floor, in the event of an emergency. Discussions with staff and management indicated that these systems and enhancements to infrastructure were in the process of being addressed at the time of this inspection.

There was a variety of communal spaces available for residents on each of the units which comprised of dining rooms, kitchenettes, day rooms and a library. These areas were decorated in a domestic homely style, many with old memorabilia and pictures of the local Wicklow countryside and seaside. There were also nicely developed external gardens for residents use, with extensive planting and furniture. In general the centre was cleaned to a good standard and there were adequate cleaning staff working in the centre. However, in one section of the centre, inspectors noted malodours over the two days. This and other findings pertaining to infection control are detailed under Regulation 27.

The inspectors saw that there was ample staff available on two of the three units on the first evening of the inspection. However, on Seafield there were not enough staff available to meet the high care requirements of the residents living there. The impact of this was that many residents remained in their bedrooms and were not appropriately supervised. Discussions with staff indicated that they were responsible for assisting a large proportion of residents with their nutrition, hydration, continence and mobility and it was exceptionally busy and difficult to attend to residents care and assist residents when they called. The inspectors also observed that a number of male residents had not been fully assisted with personal hygiene during the inspection, for example some had not received a shave. A small number of other residents had also not received adequate personal care, with eye care not completed and fingernails not cut or cleaned. Staff explained that they had been too busy to undertake this essential task. These findings are actioned under regulation 15, Staffing. The management team arranged for an increase in staffing levels on day two of this inspection, when these findings were discussed.

On day two, inspectors spent time observing the dining experience on all units. The food looked appetising and residents told inspectors that it was of good quality and they always had a choice. A large proportion of residents required assistance with their meals and this was provided n an appropriate manner by staff. However, the inspectors saw that for some residents, their independence was not always

promoted as their meal was placed on a table in front of them which was difficult to access as the residents were seated on specialised chairs, which were much higher than the table.

Inspectors also observed, over the two days, that some residents had multiple restrictive practices in use. For example; they had bedrails on both sides, bed bumpers in place and crash mats on the floors. Discussions with staff in relation to the use of these restrictive practices did not assure inspectors that they were appropriately assessed or that the least restrictive option was always used. This is actioned under Regulation 7.

Inspectors met a resident who explained that they were the residents' ambassador and represented some residents on the monthly residents meetings. This person was also known to some visitors' with whom inspectors spoke with and they informed the inspectors that any issues they had could be brought to the managers or this person. The centre had a schedule of activities which was seen to be on display in all units. Inspectors were informed that two of the activities staff were attending training at the time of the inspection. There was a care assistant allocated to provide activities, however, the inspectors observed limited social stimulation for some residents, during the inspection. Inspectors also noted and residents informed them, that they did not have access to national television stations in the centre. Therefore, they did not have access to Irish national news or their favourite television programmes, which they had conveyed at residents meetings. This is further outlined under regulation 9; Residents rights.

The next two sections of the report present the findings of this inspection in relation to 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 two day unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). The inspectors also followed up on the actions taken by the provider following findings of the previous inspection of January 2025. Findings of this inspection were that the management systems in place in the centre were not fully effective and did not provide assurance that there was appropriate oversight of the services provided to residents. Significant action was required to comply with the regulations pertaining to staffing, residents' rights, food and nutrition, the supervision of residents care, and governance and management. These findings will be detailed under the relevant regulations of this report.

The centre is owned and operated by Firstcare Blainroe Lodge Limited, who is the registered provider. The company comprises of two directors, who are also involved in the operation of 24 other designated centres in the country, and which are part of

the Emeis group. The provider employed a Regional Director, to support the centre and they were a named person participating in management on the centre's registration. They attended the centre on both days of this inspection and the person in charge confirmed they were available to them daily for consultation and support and they attended the centre at a minimum of one day per week. From a clinical perspective, the centre was being managed by an appropriately qualified person in charge. They were supported in their role by an assistant director of nursing, a clinical nurse manager and a team of registered nurses, healthcare attendants, catering, maintenance, domestic and activities staff. The lines of authority and accountability were clearly defined. The centre also had the support of a human resource personnel on site.

As referred to in the first section of this report, findings of this inspection were that the number and skill mix of staff working in the centre was found not to be adequate, when considering the high dependency needs of residents and the size and layout of the centre. This had a negative impact on residents care and also contributed to institutionalised practices which inspectors observed. An urgent action plan was issued to the registered provider, following the inspection, requiring them to review the staffing levels in the centre and to ensure that they were appropriate to meet the needs of the residents. The registered provider submitted a response within the requested time line, and provided assurances to the Chief Inspector, that these findings would be addressed. Specifically, the registered provider committed to allocating two further healthcare assistants to the day shift and increased supervision of care practices planned by the management team. The provider also committed to ceasing admissions to the centre for a four week period, until a full review was complete.

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. Additional training was also provided in areas such as falls prevention, dementia and end of life. Following the findings of previous inspections the provider had put arrangements in place for leadership and management training for clinical nurse mangers. However, findings of this inspection were that enhanced supervision of staff and the care of residents was required. This is further detailed under Regulation 16.

There were policy and procedures in place for the management of complaints. The procedure for making complaints was on display in each of the units, and in the elevator. Inspectors found that there was a comprehensive record of complaints maintained electronically for the centre, which was the responsibility of the person in charge. A recording of the investigation, actions taken and the satisfaction or otherwise of the complainant was maintained. Complaints were discussed at management meetings and areas for improvement were actioned. The person in charge submitted all required notifications to the Chief Inspector within the required time frames, as per regulatory requirements.

Residents' records were reviewed by the inspectors who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in

Schedule 4 to be kept in a designated centre were well maintained and made available to the inspectors. Records were stored securely and readily accessible. A review of staff personnel files evidence that each staff member had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021 and registered nurses had on file of their professional qualifications and active registration.

Clinical and corporate governance meetings were scheduled monthly, to review matters, including complaints, incidents, human resources and finance. The registered provider had systems in place to monitor the quality and safety of care via an audit system. Key clinical indicators with regard to the quality of care provided to residents were collected on a weekly basis and collated to develop a monthly report that was submitted to the senior management personnel to support oversight of the service. This included the incidence of wounds, restrictive practices, falls, and other significant events. However, inspectors found that these systems had failed in so far as they did not identify the deficits in the quality and safety of residents care that this inspection found. Areas of particular concern included staffing, the supervision of care delivery, nutrition and the use of restrictive practices.

Regulation 15: Staffing

The registered provider had not ensured that the number and skill mix of staff was appropriate having regards to the needs of the residents assessed in accordance with regulation 5, and the size and layout of the centre. An urgent action was issued to the provider based on this finding. On review of residents' dependency levels it was found that the majority (75%) of residents living in the centre were assessed as Maximum-/High Dependency and 72% had a cognitive impairment. Therefore, these residents would require additional assistance with mobility, continence care and maintaining adequate nutritional intake.

Insufficient numbers of staff to care for residents had a negative impact on the quality of care as evidenced by the following findings:

1. The inspectors observed some institutionalised practices in the centre. For example,

- Some residents remained in their bedrooms and only got up on alternate days. Staff conveyed to inspectors that this was due to risk of skin breakdown. However, on a review of documentation there was no evidence to support this and it was not detailed in residents care plans.
- Residents were served their evening meal at 4pm to facilitate staff routines.
- Following their evening meal a significant percentage of residents were either returned to their bed by the staff or elected to return to their bedroom, as their was little going on after that time to entice them to stay in communal areas.

2. Observations of the inspectors were that some residents' personal care, such as daily shaving and skin care, was not carried out to an appropriate standard, due to lack of staff.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors were not assured that appropriate staff supervision arrangements were in place as there was not adequate supervision of care delivery, residents nutrition and ensuring that residents rights were upheld. These practices had not been recognised, monitored or addressed by the management team.

Judgment: Not compliant

Regulation 21: Records

All records as requested during the inspection were made readily available to the inspectors. Records were maintained in a neat and orderly manner and stored securely. A sample of staff files viewed by the inspectors were found to be very well maintained and contained all the requirements of Schedule 2 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to monitor and improve the quality of the service required action to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored, evidenced by the following findings;

- There was evidence of a lack of effective systems in place to monitor staffing, as outlined further under the regulation 15.
- There was insufficient oversight of staff routine practices, such as serving meals early and residents remaining in bed.
- There was insufficient oversight by management to ensure residents rights were upheld, as detailed further under regulation 9.
- The systems in place for the management of resident's finances was not sufficiently robust, as detailed under regulation 8.
- There were not effective audit systems in place for the senior management team to assess information on each unit and to evaluate and improve the

quality and safety of the service provided to residents. Findings of this inspection were that the centres audit systems had not identified the issues identified by inspectors.

The registered provider had not ensured that resources in the centre were planned and managed to ensure person-centred, effective and safe services, specifically the allocation of health care staffing levels, as evidenced in the first section of this report.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of incidents occurring in the centre was maintained. All incidents had been reported in writing to the Chief Inspector as required under the regulations, within the required time period.

Judgment: Compliant

Regulation 34: Complaints procedure

There were policy and procedures in place for the management of complaints. The procedure for making complaints was on display in the centre in numerous areas. Inspectors found that there was comprehensive recording of complaints and complaint logs were maintained electronically. Records included any investigations carried out, actions taken and the satisfaction or otherwise of the complainant. Complaints were discussed at management meetings and areas for improvement were identified and actioned.

Judgment: Compliant

Quality and safety

Inspectors found that the quality and safety of care provided to residents was compromised as a result of ineffective systems of governance and management described in the first section of this report. Action was required in relation to residents' rights, food and nutrition, assessments and care plans, and in the use of restraint.

Residents had good access to local general practitioner services, including an out of hour's service. They also had access to a community intervention team and an advanced paramedic, who could attend the centre to review residents. This had a positive impact on residents as it prevented them from having to attend hospital for procedures such as catheter changes. There was evidence that residents were referred to specialist services such as dietetics, speech and language therapy, and tissue viability nursing. Wound care practices within the centre were found to be good and were based on evidence based nursing care.

Residents' records evidenced that a comprehensive assessment was carried out for each resident prior to admission. Validated assessment tools were used to identify clinical risks such as risk of falls, pressure ulceration and malnutrition. All residents had a care plan in place and these were developed within 48 hours of admission to the centre, as required by the regulations. However, on review of a sample of five care plans, some did not contain sufficient detail to direct care. These and other findings are set out under regulation 5. Medication management practices were found to be in line with best practice. An electronic system of prescribing and recording had been implemented and staff reported that it was working well to date.

Inspectors identified some examples of good practice in the prevention and control of infection. Infection prevention and control information and reminders were displayed on designated notice boards around the centre and there were adequate hand washing sinks available for staff. Cleaning staff were allocated to each unit within the centre. There were good systems in place in the centres laundry to segregate linen. However, some practices were also identified which had the potential to impact on the effectiveness of infection prevention and control within the centre. Findings in this regard are presented under Regulation 27.

Staff had completed up-to-date training in the prevention, detection and response to abuse. Staff spoken with were knowledgeable about what constituted abuse and what to do in instances of suspected or alleged abuse. The provider was a pension agent for six residents living in the centre. However, the arrangements in place to oversee the management of this service required review. For example; inspectors found that the arrangements in place to return monies to the estate of deceased residents was not sufficiently robust. This finding is actioned under Regulation 8, Protection.

The inspectors observed staff engaging with residents who exhibited behavioural and psychological symptoms of dementia. Engagement was respectful and non-restrictive. All staff had received training on the management of responsive behaviours. However, there was a high use of bedrails with 25% of residents' assigned bedrails. From discussions with staff it was evident that for some residents alternatives had not been trialled and there was not a clear rationale for the use of bedrails and crash mats together. Further actions were required to ensure that restraints are not used as a result of family wishes and requests and that there is appropriate multidisciplinary assessment and consent obtained. These findings are actioned under Regulation 7. The management team acknowledged these findings

and informed inspectors that a quality improvement plan was currently being implemented, to include a comprehensive review of all restraint in use in the centre.

Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required. As discussed in the first section of this report inspectors were not assured that meals were served at reasonable times ot that there was a sufficient choice of nutritious and wholesome snacks easily available to residents. These findings are actioned under Regulation 18; Food and nutrition.

The management of fire safety was kept under review and the provider was in the process of implementing all required actions identified on the previous inspection. As mentioned earlier in the report, the lower ground floor remained unoccupied at the time of this inspection. There had been engagement with the Office of the Chief Inspector with regards to this following the inspection of January 2025. The provider had agreed that there would not be admissions to this part of the centre until all fire safety issues were addressed. Inspectors were informed that new evacuation equipment had been purchased for this floor and staff were in the process of being trained in its use. The centre was provided with emergency lighting, fire-fighting equipment and fire detection and alarm system. Fire records were well maintained and evidenced that equipment was being serviced at appropriate intervals. Notwithstanding, the positive actions taken by the provider to improve fire safety, some further areas were identified on this inspection in relation to evacuation drills and daily checks. These are further detailed under Regulation 28.

Residents' meetings were convened monthly, to ensure residents had an opportunity to express their concerns. However, significant action was required to ensure residents rights were respected as detailed throughout this report and under Regulation 9.

Regulation 18: Food and nutrition

Action was required to comply with the requirements of this regulation based on the following findings:

- Mealtimes were compressed together as there was seven hours between breakfast at 9am and supper at 4pm. Therefore, this meant that there was a gap of 17 hours between supper and breakfast.
- Inspectors were not assured with regards to the nutritional content of the snack served at 6:30pm, as inspectors saw residents were served a cup of tea and a biscuit.
- There was a lack of choice of food available to residents in the units, if they chose to have a snack at times other than mealtimes, as there was a limited number of yogurts, biscuits and cereal available.
- Action was required to ensure that residents who used specialised wheelchairs were assisted at mealtimes. This was particularly in relation to

ensuring that their meals were placed in close enough proximity to them, to access and eat independently.

Judgment: Not compliant

Regulation 27: Infection control

Action was required to ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control in community settings published by HIQA. This was evidenced by:

- Crash mats, stored in some residents' bedrooms were observed to be unclean.
- A shower chair, stored in a communal bathroom was visibly unclean.
- Although the general environment and residents' bedrooms and communal areas inspected appeared visibly clean, there was a persistent malodour on one corridor over the course of the two days.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While the registered provider had a plan to address findings of the previous inspection pertaining to fire safety and had committed to having these completed by 30/09/25, some further actions were required due to the following findings:

- Although fire drills were being undertaken the inspectors were not assured from these drill records that the centres largest compartment, could be evacuated in a timely manner, when staffing levels were at their lowest. The provider is required to regularly undertake these drills with all staff to ensure they are competent to carry out a full compartmental evacuation, when staffing is at its lowest.
- Daily fire safety checks were being completed Monday to Friday, however, there was not a staff member allocated to these checks at the weekend, to provide assurance that safety measures were in consistently in place.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medicine management practices observed and described to the inspectors were found to be safe. Nurses maintained a register of controlled drugs, which was checked and signed twice daily, by two nurses. Medication reviews and audits took place on a regular basis. Where medication errors occurred, learning was identified and systems were enhanced if required.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Based on the sample of care plans viewed, some action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- The advice of healthcare professionals, such as dietitians was not always incorporated into care plans.
- Some information in care plans was generic and not specific to the residents care requirements.
- Where residents required to be repositioned, due to a high risk of skin breakdown, this was not detailed in their care plan. Specifically, it stated to reposition the resident regularly. However, from discussion with staff it was evident that this was required every two hours. This lack of specific information may result in missed care.
- A mobility plan was not accurate for one resident which stated that they had full access to get out of bed on one side, however, there were bedrails on both sides of the bed preventing this mobility.
- A resident post a fall did not have their care plan updated and sufficient documentation of their observations, as per the centres post fall protocol.

Judgment: Substantially compliant

Regulation 6: Health care

Tissue viability expertise was available to support nursing staff with the management of wound care. There was evidence that residents were referred to other health and social care professionals such as dietitians, speech and language therapist and palliative care services as required. A number of general practitioners visited the centre and residents were facilitated with a choice of general practitioner.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Action was required to comply with this regulation evidenced by the following findings:

- Where bed rails were in use for one resident the inspectors found there was absence of an appropriate risk assessment. This was necessary to ensure risk was being appropriately assessed and the use of bedrails was being monitored, to prevent the risk of injury to the resident.
- Where bedrails were in use inspectors were not satisfied that alternatives had been trialled and the least restrictive option was always used.

Judgment: Substantially compliant

Regulation 8: Protection

Action was required to ensure residents finances were safeguarded, evidenced by the following findings:

- The provider was acting as a pension agent for four residents living in the centre. However, accrued monies in these specific accounts were not made available to the residents and the residents were unaware of how much monies were accrued. Residents were not provided with financial statements, as to what monies they had in their accounts to enable them to make informed decisions as to how they spent their monies. The centres policy stated that they should receive such statements.
- The registered provider held monies belonging to eight residents who were deceased in the centre. Although there had been attempts by the head office to return these monies to the estates of some of the residents, there were substantial amounts of monies held for prolonged periods, which required return or transfer to the states solicitor.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Significant action was required to ensure that residents' rights and choices were respected, evidenced by the following findings:

- Inspectors were not assured that all residents were offered choices with regards to where they would like to spend their day. Findings of this inspection were that some residents were not afforded choice to leave their

room and only accessed communal rooms on alternate days, due to staffing constraints. This institutionalised practice did not respect residents' rights.

- Some residents did not have facilities for occupation and recreation or opportunities to participate in activities. Inspectors saw on day two of the inspection residents remained in the day room with music on the television for the day.
- National television channels were not always available for residents. A review of residents meetings evidenced that residents had brought this to the attention of the management team and requested that it be addressed. However, it had not been addressed at the time of the inspection. Therefore, residents had limited access to information and news.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Firstcare Blainroe Lodge OSV-0000016

Inspection ID: MON-0047409

Date of inspection: 12/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
A review of resident dependencies and staffing skill mix has been completed. As a result, two additional Health Care Assistants (HCAs) have been rostered each day to meet the residents' assessed needs and preferences in a more person centred and individualised way, in line with resident rights. This has been in place from 14/06/2025.

This staffing adjustment supports residents requiring increased assistance with hygiene, incontinence care, nutritional intake and provides opportunities for improved choice for all residents specifically in the areas of a positive mealtime experience, access to activities at various times of the day and mobilising- complete

Staffing allocations and resources have been reviewed and aligned with current dependency levels and individual resident needs- commenced on 14/06/2025 and ongoing

From 1st July 2025, the PPIM will oversee rosters weekly in the home to ensure that staffing numbers and skill mix remains in line with resident dependencies.

A revised Statement of Purpose outlining the revised staffing in line with dependencies and needs of the residents, as well as an application to vary, was submitted on 18th July 2025.

An additional ADON is currently being recruited, pending this recruitment, an experienced clinical nurse manager is being redeployed to support supervision and oversight in the centre- this additional support will be in place week commencing 28th July 2025.

Further training, to ensure all staff have adequate awareness of residents' preferred routines and assessed needs, including respecting resident rights, skin integrity, prevention of pressure ulcers and incorporating the recommendations of MDT referrals is being delivered to staff and will be complete by 30/08/2025.

All staff onsite have completed coaching in personal hygiene and care, with enhanced management supervision now in place to ensure ongoing compliance with standards- complete

A care plan review to ensure all care plans reflect resident current needs and guide staff appropriately has commenced and will be complete by 30/08/2025.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
To enhance supervision of residents, 2 additional HCAs have been rostered per day. This also facilitates an experienced/ SHCA to supervise the delivery of care to residents. This has been in place since the 14th June 2025.

An additional ADON is currently being recruited, pending this recruitment, an experienced clinical nurse manager is being redeployed to support supervision and oversight in the centre- this additional support will be in place week commencing 28th July 2025.

Non-urgent administrative tasks have been redeployed to allow for increased clinical supervision by the ADON to ensure resident choices are respected and person-centred care is delivered to a high standard- complete and ongoing

To further enhance supervision and oversight at weekends and at night, a number of unannounced visits to the centre out of hours (night duty and weekends) by ADON, PIC and PPIM have been completed and will be continued at regular intervals. This is in addition to the CNM on duty already in a fully supernumerary role rostered each day of weekend- complete and ongoing

In addition, external auditors have conducted an unannounced observational audit to ensure compliance with agreed practices and to provide additional feedback to the PIC and management team- complete and ongoing

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of resident dependencies and staffing skill mix has been completed. As a result, two additional Health Care Assistants (HCAs) have been rostered each day to meet the residents' assessed needs and preferences in a more person centred and individualised way, in line with resident rights. This has been in place from 14/06/2025.

From 1st July 2025, the PPIM will oversee rosters weekly to ensure that staffing numbers and skill mix remains in line with resident dependencies.

Staffing allocations and resources have been reviewed and aligned with current dependency levels and individual resident needs- commenced on 14/06/2025 and ongoing

A revised Statement of Purpose outlining the revised staffing in line with dependencies and needs of the residents as well as an application to vary was submitted on 18th July 2025.

An additional ADON is currently being recruited, pending this recruitment, an experienced clinical nurse manager is being redeployed to support supervision and oversight in the centre- this additional support will be in place week commencing 28th July 2025.

Non-urgent administrative tasks have been redeployed to allow for increased clinical supervision by the ADON to ensure resident choices are respected and person-centred care is delivered to a high standard- complete and ongoing

A review of the current activity schedule has been completed and additional activities have been scheduled in the evening period, following meals, to provide opportunities and choice for residents to stay in communal areas or remain in their bedrooms- complete

An activity calendar for each unit to guide the staff to support residents with an improved choice of activities. Residents will be consulted for their feedback to ensure the choice of activities is appropriate at the next Resident Council Meeting on 19/08/2025.

A review was conducted with the external catering service provider and the Head of Catering services to ensure evening meals are served at times that meet residents' preferences. To support this, a resident meeting was held specifically to discuss this matter and gather direct feedback - Complete

From 1st July, activities and mealtimes will remain on the agenda for all Resident Council meetings to ensure that residents are consulted, their preferences met, and their rights upheld. The PIC will attend or review all resident feedback and develop timebound SMART action plans in response.

A monthly statement of financial transactions and balances is issued to each resident

and/or their nominated representative (as appropriate) where the registered provider acts as pension agent. From 1st July, this will be reviewed in the monthly governance meeting to ensure that all residents or their representatives have received their copy of their monthly statements. There is a tracker in place to evidence compliance with this process.

A review of seating has been completed in the dining rooms to provide an enhanced mealtime experience for residents. A staff nurse is assigned to supervise each dining area during mealtimes- complete
In addition, from 1st July 2025 the ADON/PIC conducts walkarounds during mealtimes to ensure the residents are assisted by staff in accordance with their assessed needs and preferences.

From 1st July 2025, daily walkabouts completed are documented by a clinical manager, findings are discussed with staff and actions are identified to drive improvement. Trends in these walkabouts are discussed at weekly team meetings to ensure that appropriate actions are taken.

The audit tools currently used in the centre are under review by Quality Manager and will be updated as required to assist in identifying any issues and opportunities for learning in the centre, in a more timely manner. This review has commenced and an enhanced dashboard is due for roll out by 31st October 2025.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A review of current mealtimes has been completed to ensure that meals are appropriately spaced throughout the day. Resident meetings have been held to confirm individual meal time needs and preferences. Feedback has been taken into account as part of this review.The updated meal schedule is as follows:
• Breakfast – Served from 8:30 AM
• Lunch – Served from 12:30 PM
• Evening Tea – Service begins at 4:45 PM
• Supper / Evening Snack – served from 7 PM

The evening tea trolley is served from 7pm. A discussion is currently undergoing with the resident committee to further review the timing of evening tea to extend this to after 8pm.There is variety of snacks such as yoghurt, rice pudding, custard, crisps and variety of sandwiches available at this time- complete and ongoing

Following the review above and from 21st June 2025, residents have access to a large variety of nutritious snacks in all lounges at any time, 24/7.The stock is monitored and replenished daily. A checklist is available in each kitchenette to ensure adequate stock

levels are maintained at all times. This checklist is checked and signed daily by the Staff Nurse. Additionally, a weekly check is carried out by the PIC/ADON/CNM to ensure compliance.

A review of seating has been completed in the dining rooms to provide an enhanced mealtime experience for residents. A staff nurse is assigned to supervise each dining area during mealtimes- complete

In addition, from 1st July 2025 the ADON/PIC conducts walkarounds during mealtimes to ensure the residents are assisted by staff in accordance with their assessed needs and preferences.

The group catering lead is currently reviewing the meal delivery process and will make recommendations for a more efficent process for the centre. This review will be completed and any changes implemented by 30th September 2025

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A review of the equipment cleaning schedule has been completed and deep cleaning of crash mats has been increased to twice weekly- complete

From 14th July 2025, observational audits on equipment cleaning have completed by PIC/ADON during daily walkabouts.

Daily walkabouts are completed by PIC/ADON/CNM and any Infection Prevention Control issues noted including, cleanliness of equipment are discussed in the safety pause meeting and handovers. Meetings with managers, which were previously held bimonthly, have been changed to weekly starting from 15th July 2025 and the trends in these walkabouts are discussed at weekly team meetings to ensure that appropriate actions are taken- complete

Housekeeping staff meeting has been completed to review duties and to ensure that communal areas are checked frequently throughout day. The housekeeping supervisor has overview of this and it is operational from 16th June 2025.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A fire drill was completed on 17th June in the largest compartment of the home with full evacuation with a nighttime staffing scenario- complete

From 1st July, further regular drills will be scheduled with a plan to complete at least one drill monthly in the largest compartment with different scenarios such as weekend and night time staffing levels- complete and ongoing

CNMs are assigned to complete daily fire safety checks at weekends and spot checks have been completed by PIC to ensure compliance- complete

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
One to one mentoring is being rolled out to all nurses to ensure all resident care plans are person centered and to include all specific details to support resident's preferences, health needs and conditions. This will be completed by 30th August 2025.

The PIC and ADON are completing an audit of resident care plans to ensure care plans are reflective of residents' current preferences, needs and contain key information pertinent to their care. Feedback and learning will be shared with nursing team. This will be completed by 30th of September 2025.

Staff nurses have been reminded to compete all necessary assessments and observations to be completed as per the centre's policy. An information session is arranged to enhance nurse knowledge and awareness of post fall assessment, observation and care plan documentation, in line with the centre's Falls Policy and best practice. This will be completed by 30th of September 2025.

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:
A comprehensive review of all restrictive practices and self-assessment of restrictive practices has been commenced, to assist in reducing the number of restrictive practices in the centre. This will be completed by 30th of August 2025.

All risk assessments are being updated to include the alternatives trialed, with the support of MDT input. This will be completed by 30th of August 2025.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A monthly statement of financial transactions and balances is issued to each resident and/or their nominated representative (as appropriate) where the registered provider acts as pension agent. From 1st July, this will be reviewed in the monthly governance meeting to ensure that all residents or their representatives have received the copy of their monthly statements. There is a tracker in place to evidence compliance with this process.

Each resident's care plan includes specific guidance for staff on supporting residents to access their funds safely and appropriately- complete

Residents are provided with lockable storage in their bedrooms. They also have an option to use a secure safe located in the Director of Nursing's office for additional protection of valuables or funds. Residents are aware of this arrangement however this will be highlighted again to residents at the next Resident Council meeting on 19th of August 2025.

The finance department continues to actively engage with the State Solicitor's Officer to ensure appropriate management of deceased residents accounts and each case will be managed on an individual basis, in accordance with each residents' specific circumstances.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Residents are provided with a weekly activity calendar and this is displayed in each sitting room. Residents are offered choices and their choice will be respected. Resident preferences choices will be recorded in their care plan to ensure all staff are guided appropriately to support residents. This care plan review commenced on 20/06/2025 and will be completed by 30/08/2025.

A review of the current activity schedule has been completed and additional activities have been scheduled in the evening period, following meals, to provide opportunities and

choice for residents to stay in communal areas or remain in their bedrooms- complete

An activity calendar for each unit to guide the staff to support residents with an improved choice of activities. Residents will be consulted for their feedback to ensure the choice of activities is appropriate at the next Resident Council Meeting on 19/08/2025.

The television service provider has resolved the issues and all residents have access to the local channels-complete

New activity resources have been ordered to ensure each sitting room is equipped with materials for resident engagement at any time. These will be fully in place by 15/08/2025.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Red	16/06/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	28/07/2025
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	01/07/2025
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food	Not Compliant	Orange	01/07/2025

	and drink which are wholesome and nutritious.			
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Orange	01/07/2025
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Orange	16/06/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	16/06/2025
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	31/10/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the	Substantially Compliant	Yellow	15/07/2025

	standards published by the Authority are in place and are implemented by staff.			
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	30/06/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/06/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with	Substantially Compliant	Yellow	30/09/2025

	the resident concerned and where appropriate that resident's family.			
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	30/08/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	19/08/2025
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident is facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media.	Not Compliant	Orange	30/08/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	30/08/2025
Regulation 9(2)(b)	The registered provider shall provide for residents	Not Compliant	Orange	30/08/2025

	opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/08/2025