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:	Our Lady of Lourdes Care Facility
Name of provider:	Melbourne Health Care Limited
Address of centre:	Kilcummin Village, Killarney, Kerry
Type of inspection:	Unannounced
Date of inspection:	09 October 2025
Centre ID:	OSV-0000265
Fieldwork ID:	MON-0048059

About the designated centre

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

Our Lady of Lourdes Care Facility is a designated centre located within the rural setting of the village of Kilcummin and a short distance from the town of Killarney, Co. Kerry. It is registered to accommodate a maximum of 66 residents. It is a two-storey facility set out in three wings: Dun Beag is a dementia-focused unit accommodating 18 residents; Tus Nua on the first floor accommodating 27 residents; and Deenagh on the ground floor accommodating 21 residents. Our Lady of Lourdes Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, dementia care, convalescence, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 9 October 2025	09:20hrs to 19:00hrs	Siobhan Bourke	Lead
Thursday 9 October 2025	09:20hrs to 19:00hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

This was an unannounced inspection, which was carried out over one day, by two inspectors of social services. The inspectors spent time observing staff interactions with residents, the care environment and the quality of care being provided to residents. The inspectors met with many of the residents and spoke with 13 residents in more detail to hear about their experience of living in the centre. The majority of the residents were full of praise for the staff working there, especially their kindness and attention to their needs. Residents told inspectors they felt safe living in the centre. Some of the residents living in the centre, had a diagnosis of a cognitive impairment and could not converse with inspectors. The inspectors saw that these residents were very comfortable in the presence of staff. The inspectors met with six visitors who gave positive feedback on the care provided to their relatives.

Our Lady of Lourdes Care Facility has three units and can accommodate 66 residents over two floors. Deenagh with 21 beds on the ground floor and Tus Nua with 27 bed and Dunbeg with 18 beds on the first floor. Bedrooms were of adequate size and layout and could accommodate a bedside locker and armchair. Many residents bedrooms were personalised with family photographs and memorabilia of significance to the residents. Low low beds, crash mattresses and specialised pressure relieving mattresses were available, where required. The inspectors saw that the privacy curtains in the twin rooms had been replaced since the previous inspection and gave the rooms a more homely feel. However, some of these were off the curtain hooks and were hanging down, this was addressed during the inspection. Flat-screen televisions were wall-mounted in bedrooms. However, due to the lay out of some twin bedrooms, the television was not visible from one bed space.

The inspectors saw that flooring in a number of bedrooms required repair, many of the bedrooms, especially in Dunbeg Unit needed maintenance with regard to paintwork and woodwork throughout. Additionally, several window curtains were poorly fitted and not hanging correctly, which detracted from the overall appearance and upkeep of the environment. This is discussed further in the report.

Work was in progress to raise the height of the balconies that could be accessed from residents' bedrooms in Tus Nua, this would mean that when this work was completed, residents could freely access this lovely area from their bedrooms and enjoy the great views from the centre.

The centre had a number of communal spaces that in general, were warm and well maintained. Outdoor space was independently accessible for all residents living in the centre. However, the balcony area, opening out from the first floor sitting room was poorly maintained, with weeds growing between the paving slabs and paint peeling off furniture. Two raised planter beds appeared unstable as the wooden supports were broken. Additionally, a large wooden bird feeder, which had been

discarded in this area, posed a potential trip hazard for residents. An immediate action was agreed with the registered provider representative on the day of the inspection relating to the planter beds and bird feeder. Findings in this regard are further discussed under Regulation 17; Premises.

Clinical hand washing sinks were readily available along corridors. These conformed to the recommended specifications for clinical hand wash sinks. The infrastructure of the on-site laundry on the first floor supported the functional separation of the clean and dirty phases of the laundering process. The main kitchen was clean and of adequate in size to cater for resident's needs. However, other ancillary facilities did not support effective infection prevention and control. For example, there was no dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment. Clinical rooms were available for the storage and preparation of drugs, clean and sterile supplies. However, clinical hand washing sinks were not available in all clinical rooms. Sluice rooms within Deenagh and Tus Nua were equipped with bedpan washers for the reprocessing of bedpans, urinals and commodes. However, the bedpan washer on Tus Nua was out of order and appropriate contingency arrangements had not been implemented. Findings in this regard are presented under Regulation 27; infection control.

The inspectors observed the lunchtime and evening meal on the day of inspection. The dining experience in Deenagh had been enhanced, since the previous inspection, as residents now had two sittings, so that more residents could use the space allocated there for dining. There was a great choice for each meal and menus were displayed along with picture menus. Residents gave very positive feedback regarding the quality and choice of food available for each meal. Many residents required assistance and the inspectors saw that the majority of those who did, were provided with it, in a respectful and unhurried manner. However, the inspectors observed that two residents had their lunch time meals left in front of them, for long periods of time without staff either assisting them or prompting them to eat their meals. This is discussed further in the report.

Visitors were welcomed in the centre and confirmed that visits were unrestricted. There was a varied schedule of activities available for residents that were held over seven days of the week that included one-to-one and group activities. Many of the residents told the inspectors they particularly enjoyed the group exercise sessions and music sessions held in the centre. During the day, inspectors saw residents participate in an exercise session, a bingo session and lively discussions about the upcoming elections and current affairs. The inspectors saw that staff interacted with residents in a respectful manner and knew many of the residents' preferences. Residents had access to newspapers, radios and televisions. The inspectors saw posters displaying details of advocacy services, and residents were referred to advocacy services if required. There was no records of a residents meeting held in the centre since March 2025, to ensure residents were consulted in the running of the centre as outlined further in this report.

The next two sections of the report present the findings of this inspection in relation to capacity and capability of the provider, and how this impacts 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 infection prevention and control oversight, practices and processes. The overall findings of this inspection were that the management systems in place were not effective to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. Significant action was required to comply with the regulations pertaining to governance and management, training and staff supervision, care planning, food and nutrition, infection control and premises.

Melbourne Healthcare Limited is the registered provider for Our Lady of Lourdes Care Facility and is registered to accommodate 66 residents. There was a clearly defined management structure in place. The registered provider company had two directors, one of whom was attending the centre on the day of inspection. The provider had appointed a director of clinical care and quality standards as the person participating in management(PPIM) for the centre in May 2025. The directors of the provider company and the PPIM were actively involved in the management of a number of other designated centres nationally.

The PPIM for the centre attended the centre monthly and was available by phone to support the on site management team. The person in charge was full time in position and was supported by a full time assistant director of nursing and a clinical nurse manager. A second clinical nurse manager had been recently appointed and was on induction at the time of inspection. The Chief inspector had been appropriately notified of the absence and return of the person in charge of the centre from March 2025 to July 2025 respectively.

Through a review of staffing rosters and the observations of inspectors, it was evident that the registered provider had ensured that the number and skill-mix of staff was appropriate, having regard to the needs of residents and the size and layout of the centre.

The provider had a training programme in place for staff appropriate to their roles and responsibilities. Staff were up-to-date with annual fire safety training and manual handling. From a review of the training matrix, it was evident that a large number of staff were due to attend training in the care of residents with behaviour that is challenging and infection prevention and control. Furthermore, staff supervision was not robust and required improvement.This was evident from infection prevention and control procedures observed on the day of the inspection

and lack of supervision of residents who required assistance with their meals. These and other findings are outlined under Regulation 16; Training and staff supervision.

A sample of four staff personnel files were reviewed by an inspector. There was evidence that each staff member had a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 on file, prior to commencing employment. From a sample of records reviewed, it was noted that significant gaps in employment were not accounted for in one staff file, as outlined under Regulation 21; Records.

While there was a schedule of audits in place to monitor the quality and care provided to residents, the inspectors found that the management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not sufficiently robust. This was evidenced by unsatisfactory oversight of care planning and residents records to ensure that residents needs were consistently documented and communicated to all nursing and care staff. Oversight of residents assessed needs with regard to food and nutrition also required improvement. Infection prevention and control audits were undertaken monthly and covered a range of topics including, hand hygiene, equipment and environment hygiene, waste and sharps management. High levels of compliance were achieved in recent audits. However, audits had not identified a number of infection prevention and control issues highlighted on the day of the inspection. These findings are set out Regulation 23; Governance and management.

Surveillance of healthcare associated infection (HCAI) and multi-drug resistant organism (MDRO) colonisation was also routinely undertaken and recorded. A review of records found that they were not accuate and staff were unaware that a small number of residents were colonised with MDROs including Spectrum Beta-Lactamase (ESBL) and Vancomycin-resistant Enterococci (VRE). These and other findings are outlined under Regulation 23 Governance and management.

An annual review of the quality and safety of care provided to residents had been prepared for 2024, however from review of the report provided to inspectors, much of the information pertained to 2023. From a review of a record of incidents maintained electronically in the centre, it was evident that required notifications were submitted to the office of the Chief Inspector as required.

A summary of the complaints procedure was displayed in the centre and a record of complaints raised by residents and relatives was maintained. It was evident that the complaints officer investigated complaints as they arose and put plans in place to reduce the risk of recurrence. From a review of the complaints log while there were good records of complaints maintained from June 2025 to the time of inspection, there was a large gap in the records from November 2024 to June 2025. The written response provided to complainants required inclusion of the process of seeking a review as required in the regulations. These findings are detailed under Regulation 34; Complaints procedure.

Regulation 14: Persons in charge

The person in charge was working full time in the centre and had the required experience and qualifications for the role.

Judgment: Compliant

Regulation 15: Staffing

Through a review of staffing rosters and the observations of inspectors, it was evident that the registered provider had ensured that the number and skill-mix of staff was appropriate, having regard to the needs of residents and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the training matrix found gaps in the documentation of mandatory training. For example;

- Five care staff had not completed safeguarding training
- Nursing staff required further training with regard to care planning to ensure residents assessments and care plans contained information to direct residents' care.

Additional supervision was also required to ensure consistent adherence to local infection prevention and control guidelines. Findings in this regard are presented under Regulation 27.

Supervision of staff to ensure that residents were supported with their assessed nutritional and hydration needs was required as evidenced under Regulation 18; Food and nutrition.

Judgment: Not compliant

Regulation 21: Records

An inspector reviewed a sample of four staff files and found that one record had significant gaps in the person's employment records which is not in line with Schedule 2 of the regulations. All staff files had appropriate garda vetting disclosures in place.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provided did not ensure that the centre had sufficient resources to ensure the premises was maintained in accordance with the statement of purpose as detailed under Regulation 17; Premises.

Management systems required action to ensure that the service provided was safe, appropriate, and consistently monitored as evidenced by the following findings;

- Oversight of risk required action; inspectors were required to issue an immediate action to the provider with regard to the maintenance of the first floor balcony. The inspectors saw whereby a discarded broken bird feeder on the ground was a trip hazard to residents and two broken raised plantar beds were at risk of falling on residents. These were removed by the provider on the day of inspection. An excessive number of oxygen cylinders(six) were inappropriately stored in a first floor storage room; these were also removed on the day of inspection.
- There was a lack of oversight of resident care plans as a review found that accurate information was not recorded in residents' care plans to effectively guide and direct care, as detailed under Regulation 5; Individual assessment and care plan.
- Disparities between the finding of local infection prevention and control audits and the observations on the day of the inspection (as detailed under Regulation 27) indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.
- Surveillance of MDRO colonisation was not comprehensive. As a result, there was some ambiguity among staff and management regarding which residents were colonised with MDROs including VRE and ESBL.
- there was a lack of oversight of maintenance issues. For example, one bedpan washer was out of order. However, staff had not reported this issue.
- Improved supervision was required to ensure residents food and nutrition needs were met was required as outlined under Regulation 18; Food and nutrition.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of notifications found that the person in charge of the designated centre notified the Chief Inspector of the outbreak of any notifiable or confirmed outbreak of infection and other required notifications as set out in Schedule 4 of the regulations, within the required time frame of their occurrence.

Judgment: Compliant

Regulation 32: Notification of absence

The provider ensured the Chief Inspector was appropriately notified of the absence of the person in charge in March 2025.

Judgment: Compliant

Regulation 34: Complaints procedure

From a review of the records of complaints in the centre, complaint records were maintained from June 2025 to October 2025, however there was a gap in records from November 2024 to June 2025.

While there was evidence that a written response outlining if the complaint was upheld and action taken to learn from the complaint received was provided by the complaints officer, this response did not include details of how to seek a review of the complaint.

The procedure displayed in the centre and the centre's policy required updating to reflect the current review officer for the centre.

Judgment: Substantially compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

The provider ensured that suitable procedures and arrangements were in place for the management of the centre, and these arrangements have been notified in writing to the Chief Inspector during the absence of the person in charge and their subsequent return to the centre.

Judgment: Compliant

Quality and safety

Findings of this inspection, were that residents were supported with good access to health care services and opportunities for meaningful activities in Our Lady of Lourdes Care Facility. Residents who spoke with inspectors reported that they felt safe living in the centre. However, action was required with regard to care planning, food and nutrition, infection control, premises and residents rights, to ensure the quality and safety of care provided to residents, as outlined under the relevant regulations.

The inspectors found that residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as physiotherapy, dietitian, speech and language therapists, chiropodist and tissue viability as required. Multidisciplinary support and care was also provided by the Kerry Integrated Care Programme for Older People (ICPOP) Community Specialist Team.

A number of validated assessment tools were used to assess clinical risk to residents. It was evident that residents had care plans developed within 48 hours of admission to the centre. Care plans were updated within four months. However, the majority of care plans were generic, lacked the detail required to guide staff to deliver effective, person-centred care. Action was also required to ensure that care plans were reviewed and updated, when there was a change in a resident's condition and, following a review by health care professionals, to ensure that they effectively guided staff in the care to be provided to residents. This is detailed under Regulation 5; Individual assessment and care plan.

The centre was working towards a restraint free environment and had appropriate systems in place to assess and monitor restraint in use. The inspectors observed staff providing person-centred care and support to residents, who experience responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). However, a number of staff required training in the management of responsive behaviours as outlined under Regulation 7.Managing behaviour that is challenging.

The inspectors saw that residents were offered many choices for the lunch time and evening meal and residents spoke positively, regarding the quality and variety of meals provided to them. Refreshments were offered at regular intervals during the day. The inspectors saw that residents could choose to eat their meals in the dining room and a second sitting was in place on the ground floor, to ensure residents could enjoy a sociable dining experience. However, action was required to ensure that nutritional assessments were consistently completed and other findings as outlined under Regulation 18; Food and Nutrition.

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services.

The provider had nominated the assistant director of nursing to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. The provider had access to diagnostic microbiology laboratory services and a review of resident files found that clinical samples for culture and sensitivity were sent for laboratory analysis as required. The volume of antibiotic use was also monitored each month.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, staff applied standard precautions to protect against exposure to blood and body substances during handling of waste and used linen. Appropriate use of personal protective equipment (PPE) was also observed during the course of the inspection. Notwithstanding the good practices observed, a number of issues were identified which had the potential to impact on the effectiveness of infection prevention and control within the centre. For example, equipment and the environment was not managed in a way that minimised the risk of transmitting a health care-associated infection. The overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress. These findings are set out under the Regulation 27;Infection Control.

The fire safety folder was examined and it was evident that the required quarterly and annual checks of the fire alarm, fire equipment and emergency lighting were in place. Daily and weekly fire checks were completed. The provider ensured that regular fire drills occurred in the centre and staff had access to annual fire training. Storage of oxygen required review as detailed under Regulation 28 Fire precautions.

There was a focus on social interaction led by the activity co-ordinators and residents had daily opportunities to participate in group or individual activities. Residents also had access to local and national newspapers every day. There were no visiting restrictions in place. Visits and outings with family members were encouraged and facilitated. Residents had access to independent advocacy services if required. Residents told inspectors that call bells were responded to in a timely manner. However, the inspectors found that some resident's preferences and choices were not always supported and there was no evidence available to indicate that residents meetings had been held in the centre since March 2025. These and other findings are outlined under Regulation 9 Residents Rights.

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were

encouraged and facilitated in the centre. Residents were able to meet with visitors in private or in the communal spaces through out the centre.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure the premises was maintained in line with Schedule 6 of the regulations as evidenced by the following;

- The first floor veranda was poorly maintained with weeds between paving slabs, peeling paint on furniture, rotting planters and a discarded bird feeder
- Damage from wear and tear continued to impact negatively on the centre for example surfaces and flooring in a large number of areas were worn and poorly maintained and as such did not facilitate effective cleaning. These were repeated findings from previous inspection.

Judgment: Not compliant

Regulation 18: Food and nutrition

Action was required to ensure that residents dietary needs as prescribed by dietetic staff, based on nutritional assessment in accordance with residents' care plans were met, as evidenced by the following;

- There was ambiguity regarding the nutritional regime for a resident receiving supplementary feeding and a lack of oversight of intake to ensure a resident's dietetic regime was followed.
- Two residents with weight loss did not have nutritional assessments recorded at regular intervals, in line with the centre's policy.
- Supervision of mealtimes was required to ensure residents were supported with their meals; the inspectors saw that two residents meals were left for long periods in front of them with no assistance provided from staff or prompting to encourage them to eat their meals.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

A review of documentation found that when residents were transferred to hospital from the designated centre, relevant information was provided to the receiving hospital. Upon residents' return to the designated centre, staff ensured that all relevant clinical information was obtained from the discharging service or hospital. Copies of transfer documents were filed in the residents charts.

Judgment: Compliant

Regulation 26: Risk management

The provider had ensured that a comprehensive risk management policy which met the requirements of the regulations was implemented in practice.

Following outbreaks, the person in charge had prepared outbreak reports in line with national guidelines. Reports included a time line of events, the number of residents and staff affected in addition to the infection control measures implemented. Reports also included recommendations to improve future responses.

Management systems to ensure oversight of risk required action, as outlined under Regulation 23; Governance and management.

Judgment: Compliant

Regulation 27: Infection control

The provider did not met the requirements of Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018). For example;

- Appropriate infection prevention and control precautions were not in place when caring for a resident with a history of CPE colonisation. For example, a risk assessment to inform room allocation was not undertaken and designated showering facilities were not provided.
- There was no dedicated housekeeping room. Housekeeping trolleys were prepared within the laundry which posed a risk of cross contamination. Basins used for residents person hygiene were also washed in this area which also increased the risk of cross infection.
- Sluicing facilities did not support effective infection prevention and control. A spray hose was attached to an equipment cleaning sink within both sluice rooms. The use of the hose/ spray wand also posed a very high risk for environmental contamination. Cleaning equipment was stored and prepared within the sluice rooms. This significantly increased the risk of environmental contamination and cross infection.

- Staff within one unit informed inspectors that, in the absence of a bedpan washer on the unit, they manually decanted the contents of commodes/ bedpans into toilets prior to manually cleaning. This increased the risk of environmental contamination and the spread of MDRO colonisation.
- A dedicated specimen fridge was not available for the storage of laboratory samples awaiting collection. Inspectors were informed that samples were stored within the medication fridge. This posed a risk of cross-contamination.
- Several single use wound dressings dressings were observed to be open and partially used. This may impact the sterility and efficacy of these products.
- Safety engineered sharps devices were not routinely used for taking blood samples. Inspectors observed that several of these needles had been recapped after use. This practice increased the risk of needle stick injury.
- While antibiotic usage was recorded, there was no documented evidence that this data was used to inform targeted antimicrobial stewardship audits or quality improvement initiatives.
- Alcohol based hand rub dispensers were not available at point of care (within bedrooms). A clinical hand hygiene sink was not available within the clinical room on Deenagh. The design of hand washing sinks in the sluice rooms did not facilitate effective hand hygiene.

Judgment: Not compliant

Regulation 28: Fire precautions

Oversight of oxygen storage required action; six oxygen cylinders were inappropriately stored in a first floor storage room. As they were a combustion risk, the excess cylinders were removed on the day of inspection.

The provider was working to action the findings of the fire safety risk assessment and external contractors were on site, on the day of inspection, replacing and repairing fire doors as required.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of residents' records and care plans and found the registered provider was required to take significant action to comply with the requirements of this regulation as evidenced by the following.

- Care plans were not updated when a residents' condition changed; for example when residents returned from hospital.

- A resident with significant weight loss did not have a malnutrition assessment completed in 12 months to inform care planning for the resident.
- A resident's oral assessment had not been completed in 12 months, even though the resident had complex health care needs
- While validated assessment tools were in use to assess risk to residents such as pressure ulcers or falls, these assessments were not appropriately used to inform care planning; for example when residents assessments changed, care plans were not update to reflect these changes.
- There was evidence that daily progress notes did not give a narrative of residents' care needs during the day or night and was generic information that did not reflect residents' individual needs.
- The inspectors saw that accurate infection prevention and control information was not recorded in resident care plans to effectively guide and direct the care of residents with a recent history of Clostridioides difficile infection or that were colonised with MDROs.
- The majority of residents had a generic infection prevention and control care plans in place when there was no indication for their use.

Judgment: Not compliant

Regulation 6: Health care

Residents living in the centre had good access to health care services and there was evidence that residents were reviewed regularly, when required. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible for example tissue viability, speech and language therapy (SALT) dietitian, and physiotherapy. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

While there was evidence that the provider was working to promote a restraint free environment for residents, eleven staff required training on managing responsive behaviour to ensure they had up-to-date knowledge and skills appropriate to their role with regard to responding and managing responsive behaviour.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action was required to ensure residents rights were upheld at all times as evidenced by the following;

- A residents' preferences for their food choices were not always upheld in line with their preferences, for example a resident with specialised dietary needs did not have their preferences consistently supported.
- Residents' right to go to bed at a time of their choosing and their preferences for personal care were not consistently upheld. This was due to staff routines which were not person centered.
- Ensuring residents dignity and privacy was maintained at all times was not consistent, as the inspectors saw that privacy curtains in some of the shared rooms were hanging down and would not provide adequate privacy when closed. A resident was not attended to promptly by staff, when they required assistance with their personal care.
- There was no evidence provided to inspectors that a residents' meeting had been held in the centre since March 2025, to ensure residents were consulted in the running of the centre.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of absence	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Our Lady of Lourdes Care Facility OSV-0000265

Inspection ID: MON-0048059

Date of inspection: 09/10/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
We take our responsibility for education and staff development very seriously and have actioned the following to come into compliance.

A full review of the training matrix and the supervision practices has been undertaken.

Safeguarding Training has now been completed for the 5 staff which required same.

An enhanced system for record governance has been introduced whereby the administration team will maintain the training matrix record and this will be inspected by the PIC and Director of Clinical Care Quality and Standards at the monthly governance meetings and the PIC will also review the status prior to submitting their weekly report to the Director of Clinical Care Quality and Standards – weekly plans will then be made to ensure that training is scheduled as required and so that all staff are up-to-date.

Our external training company have been booked to provide refresher education on IPC and managing responsive behaviours.

We have nominated IPC champions and they will also receive additional training.

An in-house training and mentorship programme has been devised in order to support the nursing team with the assessment and care planning aspect of their role. Progress will be monitored by the PIC and the Director of Clinical Care Quality and Standards on a weekly basis. Additional time has been allocated for the nursing team so that they can focus on enhancing these records and processes.

The management team are working with the nursing and housekeeping teams to guide and mentor them in relation to conducting productive walk arounds and which will raise greater awareness and understanding for the entire team in relation to IPC.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A full review of all staff files has taken place in order to ensure that they meet the requirements set out in schedule 2 of the regulations.

The staff file which had gaps in their employment record was corrected on the day of the inspection.

The PIC and the Director of Clinical Care Quality and Standards will "spot-check"/audit this on a monthly basis during the monthly governance meeting.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An entire risk assessment has been undertaken by the PIC, Director of Clinical Care Quality and Standards and the Registered Provider Representative (RPR) and all hazards have been identified and corrected have control measures applied.

The trip hazards were immediately removed.

The oxygen cylinders have been removed.

An in-house training and mentorship programme has been devised in order to support the nursing team with the assessment and care planning aspect of their role. Progress will be monitored by the PIC and the Director of Clinical Care Quality and Standards on a weekly basis. Additional time has been allocated for the nursing team so that they can focus on enhancing these records and processes. Audits will be conducted following this mentorship programme in order to ensure that standards are being met and maintained.

The Director of Clinical Care Quality and Standards has conducted an IPC audit using a new audit tool designed and developed from best practice guidelines. A significant action plan is now in place. The Registered Provider Representative (RPR) has authorised for an external cleaning company to conduct a deep clean of the entire centre. New cleaning schedules and processes will be subsequently implemented for the housekeeping team. The IPC champions with the home management team will monitor the adherence to the

standard expected on a daily basis.

A full review of the MDRO status for each resident has taken place and this has been discussed with all staff. Staff knowledge of this is "spot-checked" at handovers, safety pauses and on the walkarounds.

The bedpan washer has been repaired. The RPR has met with the maintenance personnel to discuss the areas requiring support and the systems in place for managing day-to-day requirements. The PIC has re-iterated to staff the importance of logging maintenance requirements. The PIC will review the maintenance requirements with the maintenance personnel on a weekly basis. Areas requiring escalation will be flagged in the weekly report submitted to the Director of Clinical Care Quality and Standards and the RPR.

A de-briefing session has been undertaken with all staff in order to understand "what went wrong" on the day of inspection in relation to the residents food and nutrition needs. Areas for improvement have been identified and lessons have been learned. The nurse in charge and the home management team will ensure that this does not happen again as they will supervise and monitor the residents meal times.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints going forward will have a response which includes details of how to seek a review of the complaint.
The procedure displayed in the centre and the centre's policy has been updated to reflect the current review officer for the centre.
Complaints training on HSEland will be completed by all members of the home management team.
A quarterly audit and analysis of all feedback is conducted and the Director of Clinical Care Quality and Standards will ensure that all feedback is managed as per policy and Regulation 34.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Following the inspection all issues identified on the first-floor veranda have been addressed. The damaged planters and the discarded bird feeder have been removed.

New external planters and new furniture (recycled plastic) for the full balcony area have been ordered and will be installed upon delivery. A painter is currently on site completing a full repaint of the veranda area, including walls, furniture, and the parapet, to ensure all surfaces are restored and appropriately maintained. The repainting works will be completed by 28/11/2025 and all new balcony items will be in place by February 2026, after which the veranda will be fully restored to a safe and well-maintained condition.

A flooring subcontractor has been appointed to replace worn and damaged flooring in the areas highlighted by the inspectors. These works have commenced on site this week. The areas being upgraded during this phase include the 1st Floor Tus Nua Day Room, the Foyer, Nurses Station, ADON Office, WC, Coffee Dock, and Bedroom 169. These works form part of the centre's capital expenditure plan and our ongoing continuous improvement programme. The current phase of flooring replacement will be completed by 26/11/2025 with further flooring upgrades scheduled throughout 2026.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A full review of all residents nutritional and supplementary needs has been undertaken.

A schedule has been developed for weight monitoring.

The nurse in charge and the home management team will supervise and monitor the residents meal times. An additional meal-time option has been added so that residents requiring support with their meals will receive this support from the staff.

As part of the care plan project, all nutritional assessments and care plans are being reviewed.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A risk assessment for CPE has been undertaken and communicated with all staff. A designated shower facility is now in place.

The RPR is reviewing the storage of housekeeping trolleys and the place whereby cleaning chemicals are prepared so that there will be no cross-contamination between

dirty and clean.

The spray hoses have been removed.

The practice of emptying the contents of bedpans and/or commodes into toilets has ceased and staff have been informed that there is zero tolerance for same. Disposable urinals and bedpans have been sourced and a contingency plan is now in place for the unit which does not have a dedicated sluice room.

A specimen fridge has been purchased.

The practice of partially using dressing packs and not disposing of same has been discussed with the nursing team and they have been informed that there is zero tolerance for same. This will be monitored by the management team on their walk arounds.

Only safety engineered sharps devices are now available in the centre. Correct disposal has been discussed with the nursing team and they have been informed that there is zero tolerance for incorrect disposal of same. This will be monitored by the management team on their walk arounds.

Data re. antibiotic usage will now be analysed rather than just gathered and a quarterly review will take place in order to ensure good antimicrobial stewardship.

The placement of alcohol-based hand rub dispensers will be risk assessed in line with new admissions and their PCRA in order to ensure access at point of care. Replacement of sinks to clinical hand hygiene sinks will be factored into the 2026 capex budget.

The Director of Clinical Care Quality and Standards has conducted an IPC audit using a new audit tool designed and developed from best practice guidelines. A significant action plan is now in place.

Refresher education on IPC has been scheduled and is ongoing for all staff

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: With regards to regulation 28, a fire compliance plan has been completed taking risk management into consideration. Work has already commenced on repairing and /or replacing fire stopping devices such as upgrading of fire doors, ensuring fire stopping construction is in place in all areas including the roofs. The oxygen cylinders have been removed from the building interior and now stored in a locked caged area external to the Nursing Home. Excess oxygen cylinders have been removed from site. Risk assessments have been completed and compliance with Fire safety is reviewed daily. Going forward a

monthly fire safety audit will be completed to ensure resident safety and compliance with regulation.

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:
An in-house training and mentorship programme has been devised in order to support the nursing team with the assessment and care planning aspect of their role. Progress will be monitored by the PIC and the Director of Clinical Care Quality and Standards on a weekly basis. Additional time has been allocated for the nursing team so that they can focus on enhancing these records and processes. Audits will be conducted following this mentorship programme in order to ensure that standards are being met and maintained.

Training from external facilitators is also scheduled.

A full review of all residents nutritional and supplementary needs has been undertaken.

A schedule has been developed for weight monitoring.

Oral assessments have been undertaken.

As part of the education and mentorship programme nurses are being reminded about the importance of linking assessments to care plans and about how to write good person centred narrative notes.

All residents care plans now contain their IPC information and MDRO status and their care plans are being individualised.

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:
Additional responsive training has been booked and the PIC and the Director of Clinical Care Quality and Standards will ensure that this is completed by all staff requiring same.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: An additional meal time is now being offered.

The PIC has met with the catering team and a full review of the residents preferences has been sought from the residents and/or their nominated support person.

Residents rising and retiring times have been discussed at the residents meetings and with staff and allocations are under review in order to meet the residents preferences.

The privacy curtains have been repaired and a further plan is in place for a complete replacement.

The importance of responding to residents in a timely manner has been discussed with the team and feedback from residents will be sought in relation to this.

A resident meeting has now taken place and will do so monthly.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	15/12/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/11/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	28/02/2026
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident	Not Compliant	Orange	21/11/2025

	as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Not Compliant	Orange	21/11/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	15/11/2025
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	31/12/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	31/12/2025

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Orange	15/02/2026
Regulation 27(c)	The registered provider shall ensure that staff receive suitable training on infection prevention and control.	Not Compliant	Orange	15/11/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant	Substantially Compliant	Yellow	31/10/2025

	whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/10/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	30/11/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared	Not Compliant	Orange	01/01/2026

	under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	15/11/2025
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.	Not Compliant	Orange	21/11/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	21/11/2025