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:	Ballymote Community Nursing Unit
Name of provider:	Nazareth Care Ireland
Address of centre:	Carrownanty, Ballymote, Sligo
Type of inspection:	Unannounced
Date of inspection:	17 January 2025
Centre ID:	OSV-0000330
Fieldwork ID:	MON-0044479

About the designated centre

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

Ballymote Community Nursing Unit is registered to accommodate 32 residents who require long-term residential care or who require short-term respite, convalescence, dementia or palliative care. The centre is located in a residential area a short walk from the town of Ballymote. The building is a single-storey building that is decorated in a homely way. A large extension was added in 2019, and a refurbishment programme for the original building was completed in 2020. Accommodation is made up of 14 single rooms, five twin rooms, and two three-bedroom rooms, which are used by short-stay residents.Residents' bedroom areas are personalised and there is appropriate screening in shared bedrooms. Signage and points of interest are located throughout the building to guide residents around the centre. The centre has safe garden areas that are centrally located and cultivated with raised beds and shrubs to make them interesting for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	31

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
Friday 17 January 2025	09:30hrs to 17:00hrs	Michael Dunne	Lead

What residents told us and what inspectors observed

On the day of inspection, the inspector observed that residents were supported to enjoy a satisfactory quality of life supported by a team of staff who were kind, caring and responsive to their needs. The overall feedback from residents was that they were happy with the care they received and their life in the centre. One resident told the inspector " that staff look after me very well" while another resident said that" they make sure that my room is clean and that I get to see the doctor when I am unwell". Residents also told the inspector that they felt safe in the centre and could freely raise any concerns with the staff. They stated that they were assured that their concerns would be listened to and addressed promptly.

Notwithstanding this positive feedback, the inspector found that there were areas of current practice where actions were required to improve the care and welfare for residents. The inspector found non-compliance with regulations, which underpin residents' safety. These are discussed under the relevant regulations and under the themes of Quality and Safety and Capacity and Capability.

This unannounced risk inspection was carried out over one day. There was one resident vacancy in the designated centre, and at the time of the inspection the centre was accommodating 31 residents. Of the 32 bed spaces available in this centre, eight were designated as respite beds and allocated to the Health Service Executive (HSE). On arrival the inspector was welcomed by care staff working in the centre and shortly after by the person in charge. Following an introductory meeting with the person in charge, the inspector was accompanied for a walk of the designated centre.

The inspector met and spoke with several residents on the walkabout and throughout the day. The majority of views expressed by residents were positive, particularly about the care provided by the staff team. The inspector observed many resident and staff interactions and found them to be based on respect for the individual. Residents who required support with their mobility or personal care were supported in a person-centred and timely manner. Call-bells were responded to within an acceptable time frame.

In instances where residents presented with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), staff were observed to respond in an appropriate manner, which de-escalated potentially risky situations while at the same time respecting the resident's autonomy and safety.

There was a calm and relaxed atmosphere in the centre. Some residents were up and about and were spending time in the communal rooms while others were still in their bedrooms. Household staff were observed attending to resident rooms, while care staff were observed assisting residents with their personal care support in a

discreet manner. It was obvious that staff were aware of residents assessed needs and this contributed to positive social interactions between them.

The premises were clean, and resident bedrooms were found to be spacious, well-maintained and suitable for the needs of the residents. All bedrooms contained adjoining en-suite toilet and shower facilities. There were suitable storage facilities available in residents' bedrooms, which facilitated easy access to their personal belongings. There were several communal facilities available for the residents to use, with both the sitting and dining room suitably furnished and laid out to meet the needs of the residents. However, there was a lack of planned maintenance in place to ensure that outside facilities were suitable for resident use.

Restrictive practices were, on the whole, well-managed, and the provider was keen to ensure that restrictive practices were only introduced as a last resort. Residents were found to have unrestricted access to all communal areas inside the centre. However access to an outside space from the dining room was blocked as one of the exit doors was locked. This was pointed out to the person in charge as this practice impacted on residents' ability to access all areas of their home.

Although the centre was clean and well-laid out to meet the needs of the residents, there were some practices that impacted on the effectiveness of the centre's infection prevention and control measures. For example, poor oversight and management of waste and storage in the sluice rooms had the potential for infection to spread in the designated centre.

There was no member of staff with overall responsibility for coordinating residents' social activities on the day of the inspection. The inspector found that social care provision was limited, and although there was a schedule of activities written on a white board leading to the main sitting room and included chair exercises and card games, the inspector did not observe these activities being provided. Outside of mealtimes and visits by relatives, most of the residents were observed to spend their day in the sitting room with the television on and listening to music. The social activities available on the day did not offer any choice to residents who preferred to participate in more active group activities. Residents commented in the residents meeting held on 5 December 2024 that they would like to know more about activities that could be provided.

Several residents commented that they liked the quality and quantity of the food provided. Meal options on the day of the inspection consisted of either a fish or ham dish. There were sufficient numbers of staff available to provide assistance and to ensure residents were supported to enjoy their meals. The inspector observed that the dining room was spacious and well set up to cater for residents. Several residents required assistance with their eating and drinking, and this was observed to be provided both in the dining room and in residents rooms.

The next two sections of the report, capacity and capability and quality and safety will describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This inspection found that management and oversight of this service was not fully effective and the quality assurance processes in place did not fully ensure that this service was safe, appropriate and met the needs of the residents.

This unannounced inspection was carried out to monitor compliance with the Health Act 2007 Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. The registered provider for this centre is Nazareth Care Ireland, which was developed by the Sisters of Nazareth in 2007. The registered provider took over the management and operation of this centre in August 2024 following a successful application to register as a new provider with the Chief Inspector. The provider is well-established in Ireland and is involved in the management of a number of other designated centres.

The person in charge (PIC) was new to their post having taken up this role in November 2024. The person in charge is supported in their role by a clinical nurse manager (CNM) and a team of nurses. The team also includes health care assistants, activity staff, maintenance staff and a part-time physiotherapist. A number of key services provided by the designated centre had been outsourced, such as housekeeping, catering and laundry support. The registered provider maintained service level agreements with the agency providing these services to ensure that the services met the agreed standards. In addition, the local management team is supported by a chief nursing officer and a quality and compliance manager who provides regular support to the team.

There were a number of systems in place to review the quality and safety of the services provided. A review of audit information in relation to infection prevention and control found that audits were not identifying poor practice in areas of service provision, and this meant that there were no action plans in place to drive the required improvements and to improve the quality of the services provided to the residents. In addition, some key-areas of service provision were not reviewed at the provider level. The governance meeting agenda was limited in terms of the key areas discussed and reviewed; for example, the meeting held in January 2025 did not reference information gathered from recent audits or make reference to risks or complaints. This meant that there was a lack of oversight of key-areas of service provision and that areas of poor practice identified on this inspection were not addressed.

The inspector found inconsistencies in the statement of purpose dated 25 November 2024 regarding numbers of whole time equivalents (WTE) for multi-task attendants and nursing staff available in the designated centre and in the statement of purpose (SOP) submitted to register the designated centre under the new provider. In addition, the number of hours allocated to the clinical nurse manager role had also reduced. A review of the rosters found that a planned absence was not covered,

which meant that residents were unable to pursue their social care activities according to the planned schedule.

The inspector was not assured the registered provider maintained sufficient staffing levels and an appropriate skill-mix across all departments to meet the assessed needs of the residents. A review of the centre's rosters confirmed that staff numbers were not in line with the staff structure outlined in the designated centre's statement of purpose submitted as part of the information required to register the designated centre. In instances where gaps appeared on the roster, not all were covered to provide an uninterrupted service. The activity resource had not been covered for a period of two days, although this absence had been planned in advance. Observations of staff and residents' interactions confirmed that staff were aware of residents' needs and were able to respond in an effective manner to meet those assessed needs.

Policies and procedures as outlined by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, were made available to the inspector during the inspection. All policies were reviewed and updated at intervals not exceeding three years to ensure the information within these policies remained current and in line with best practices.

The provider maintained a policy and procedure for complaints. Records confirmed that the provider investigated complaints in line with this policy. Six complaints were recorded since the last inspection, and all were seen to be managed within the specified timescale as outlined in the complaints policy.

Regulation 14: Persons in charge

There is a person in charge who works full-time in the centre and is well-known to residents and staff. The person in charge is an experienced registered nurse who meets the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

The inspector was not assured that the provider had the required numbers of staff available with the required skill-mix, having regard to the size and layout of the centre and the assessed needs of the resident's. For example;

- There were insufficient numbers of staff available on the day to provide social care support for the residents.

Judgment: Substantially compliant

Regulation 23: Governance and management

The designated centre had insufficient resources to ensure the effective delivery of care in accordance with the statement of purpose (SOP). This was evidenced by:

- A review of the centre's rosters confirmed that staff numbers were not in line with the staff structure outlined in the designated centre's statement of purpose submitted as part of the information required to register the designated centre.
- The centre had a deficit of approximately 2.7 whole-time equivalent (WTE) multi-task attendants.
- The clinical nurse manager (CNM) WTE hours had been reduced from 1.7 to 1.00 hours.

The quality assurance systems in place for monitoring the quality and safety of the service were not effective, and consequently, most of the inspectors' findings on this inspection had not been identified by the provider through their oversight and auditing processes. Action plans were not consistently developed to address the deficits that were identified in some audits by the provider, and evidence of completion of the action plans developed was limited. For example:

- There was no effective system in place to monitor the receipt or return of medications for respite residents.
- Audits were ineffective in identifying shortcomings in staff practices, and as a consequence, there were no action plans in place to identify improvements.

The oversight and management of risk in the centre were not effective. Consequently, there were inadequate systems in place to identify, manage and respond to risk. This was evidenced by;

- Risk assessments in use in the centre were not robust and did not provide a good level of protection to residents. For example, a resident with a Multidrug-Resistant Organism (MDRO) did not have an appropriate risk assessment in place or have a clinical waste bin provided in their room.
- Risks associated with the use of shared equipment to assist residents with their transfer were not identified or mitigated.

The annual review for 2023 and quality improvement plan for 2024 were made available for review and included feedback from residents and staff. Some improvement actions were on-going at the time of this inspection and had yet to be fully implemented. These actions included the provision of specific training and the application of all policies into practice, such as care planning.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place, which included the information set out in Schedule 1 of the regulations. However, this document required a number of changes to accurately reflect the current service, for example:

- A more transparent and accurate representation of the number of (WTE) for health care assistants and multi-task attendants working in the designated centre.
- The number of (WTE) hours allocated to housekeeping and to the laundry service was unclear.
- The (WTE) hours worked by the Respite Coordinator were incorrect.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members to lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion.

A review of the complaint's log indicated that the provider had managed the complaints received in line with the centre's complaints policy.

Judgment: Compliant

Regulation 4: Written policies and procedures

The centre's policies and procedures, as outlined in Schedule 5 of the regulations, were reviewed and updated within the previous three years. Any changes in these documents were communicated to staff in the centre's regular staff meetings.

Judgment: Compliant

Quality and safety

The findings of this inspection concluded that increased oversight was required to ensure that the quality and safety of care being delivered to residents was consistently and effectively managed to ensure the best possible outcome for residents. In particular, actions were needed to bring Regulation 23: Governance and Management, Regulation 5: Assessment and Care Planning, Regulation 9: Residents' Rights, Regulation 27: Infection Prevention and Control, and Regulation 15: Staffing, into full compliance.

Overall, residents were provided with good standards of nursing care and had access to timely health care from their general practitioner (GP), who attended the centre on a regular basis. There was also good access for residents to health and social care professional services and psychiatry services, which optimised their health and clinical well-being. A physiotherapist was directly employed by the provider and was available to the residents on a part-time basis.

Residents' care records were maintained on an electronic nursing documentation system. The inspector found that assessment and care planning required improvement to ensure each resident's health and social care needs were identified and the care interventions were clearly described. The inspector reviewed a sample of residents' care documentation and found that the information required to inform effective care interventions was not always easy to follow. The provider was aware that improvements were required in this area and had organised care planning training on the day of the inspection, with further training dates organised for staff, who were unable to attend on the day.

Residents' right to privacy and dignity were respected, and staff were observed to knock on resident's doors prior to entry and explain to the residents the purpose of their visit. The inspector observed staff interactions with a resident who had an assessed communication need and found that staff used good communication and listening skills to maximise the resident's communication.

There was a clear safeguarding policy in place that set out the definitions of terms used, responsibilities for different staff roles, types of abuse and the procedure for reporting abuse when it was disclosed by a resident, reported by someone, or observed. The process included completing a preliminary screening to decide if there was a need for further information, or to proceed to a full investigation, or whether there was no evidence that abuse had occurred. The management team were clear on the steps to be taken when an allegation was reported. Social care support was not available on the day of the inspection and there was no staff member allocated to carry out this role on the day prior to the inspection. The inspector was not assured that residents participation and enjoyment in the activities provided were accurately monitored to ensure that residents were provided with activities in accordance with their interests or capacities. The inspector observed that residents located in the sitting room did not have much to do apart from watching television.

There were opportunities for residents to give feedback on the quality of the service provided in monthly resident meetings. Areas of the service discussed included

catering, premises, laundry, call-bells, maintenance and activities. Records relating to the residents' satisfaction survey for 2024 were not available for review, and the inspector was informed that the annual review for quality and safety in 2024 was not yet complete.

There were measures in place to protect residents against the risk of fire. These included regular checks of means of escape to ensure they were not obstructed and checks to ensure that equipment was accessible and functioning. The provider maintained and updated resident personal emergency evacuation plans (PEEPS) as and when required to aid resident evacuation in the event of a fire emergency. The provider also ensured that fire drills were carried out to ensure the fire procedure was well-known among the staff. The provider was aware that some fire doors were not closing properly and that a number of gaps were visible when these doors were closed. At the time of this inspection the provider had received a report from a competent person and was now in the process of upgrading the work on the fire doors. A review of the smoking shelter found that it was unsuitable for resident use as it did not contain the required levels of detection. Currently, one resident in the centre was a smoker, and they were supervised when they wished to have a smoke.

Overall, the premises were well-laid out to meet the needs of the residents. The centre was clean and tidy. Communal rooms were comfortably furnished and nicely decorated. Corridors were wide, internal surfaces were well-maintained and there were handrails in place to assist residents with their mobility. External facilities required improvement to ensure that residents could enjoy the garden area safely.

Residents' bedrooms were mostly single occupancy with five twin bedrooms and two three-bedded bedrooms also available. All bedrooms were en-suite with toilet and shower facilities. Residents had enough storage for their personal possessions, including a lockable storage space if they wished. Bedrooms were personalised with photographs and memorabilia from the resident's home. Residents said that their bedrooms were comfortable and they enjoyed their personal space.

The inspector found weaknesses in the overall management of infection control and, in particular, in the oversight and identification of risk in relation to current practices. These issues are discussed in greater detail under Regulation 27: Infection control.

Regulation 10: Communication difficulties

The registered provider ensured that residents who required assistance with their communication needs were provided with the required levels of support to assist with communication. For example;

- The clinical team developed a care plan for a resident who had difficulty verbalising their care needs. The care plan identified the most effective

communication methods to assist the resident communicate their views. These interventions were based on a sound knowledge of the individuals communication preferences.

Judgment: Compliant

Regulation 17: Premises

The provider had failed to ensure that one of the courtyards was well-maintained and suitable for resident use. This was a repeat finding from the previous inspection. This was evidenced by:

- The paved surface was uneven and had the potential to cause a trip hazard.
- The garden was not well-maintained, and there were uncontrolled weeds in some areas.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy in place that met the requirements of Regulation 26.The failure of the provider to identify and manage risk is discussed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures consistent with the National Standards for Infection Prevention and Control in Community Services (2018) published by HIQA were fully implemented by staff.

The registered provider had not ensured clear governance arrangements were in place to achieve the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. Current monitoring, audit and oversight arrangements had not identified areas for improvement highlighted by an inspector during the course of the inspection. For example:

- Sharps containers were found in a sluice room with the closure mechanisms disengaged.
- General waste items were stored in the clinical waste bins.

- Wheelchair foot plates were found on the rack in the sluice room.
- A resident with a history of an MDRO (Multidrug-resistant organisms) infection did not have a clinical waste bin in their room.
- There was no system in place to ensure that communal equipment used to transfer and mobilise residents was cleaned in between resident use.

Judgment: Substantially compliant

Regulation 28: Fire precautions

At the time of the inspection, the registered provider had not taken all adequate precautions to ensure that residents were protected from the risk of fire. For example:

- Several fire doors did not have effective intumescent strips and smoke seals in place to stop the spread of smoke or combustible fumes.
- There were penetrations in the ceiling of the laundry and in the hot press store that required fire stopping.
- Self-closing devices on a small number of fire doors required adjustment to ensure the effective closing of fire doors.
- The smoking shelter did not have a heat sensor or call-bell in place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A number of resident plans did not contain the necessary information to guide effective care delivery and the inspector found that the link between the development of robust care plans based on an updated risk assessment was not always evident. For example:

Assessment and care planning required improvement to ensure each resident's health and social care needs were identified and the care interventions that staff must complete were clearly described. The inspectors reviewed a sample of residents' care documentation and found the following:

- Care plans did not clearly distinguish between the goals and interventions.
- There was no care plan developed for a resident with a colonised MDRO (Multidrug-resistant organisms) infection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) of their choice. GPs visited residents in person and were contacted and made aware if there were any changes in the resident's health or well being. Allied health professionals such as dietitian, physiotherapist, occupational therapist, speech and language therapy, and tissue viability nurse were made available to residents, either remotely or on-site, where appropriate.

Judgment: Compliant

Regulation 8: Protection

The inspector was assured with the measures in place to safeguard residents and protect them from abuse. Safeguarding training was up to date for staff. Staff were aware of their responsibilities to report concerns and were familiar with the content of the safeguarding policy.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were not always provided with opportunities to participate in activities in accordance with their capacities and capabilities. For example:

- The organisation and availability of social care support were not well-managed to ensure that residents were provided with activities in line with their assessed needs. There was insufficient oversight of resources in place to ensure that residents had access to a planned schedule of activities seven days a week.
- The inspector found gaps in the recording of resident’s participation in activities, and it was difficult to identify the activities residents attended.

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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ballymote Community Nursing Unit OSV-0000330

Inspection ID: MON-0044479

Date of inspection: 17/01/2025

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing Levels Review: • A full review of staffing levels and skill-mix has been undertaken, considering the size, layout of the centre, and resident needs. • Staff have been recruited, and we are actively seeking to fill any remaining vacancies. • Social Care Support Enhancement: • A designated staff member has been assigned to focus on social care activities to ensure residents receive adequate engagement and stimulation. • The activities program has been reviewed and enhanced to align with residents' preferences and needs. • Ongoing Workforce Planning & Monitoring: • Staffing levels will continue to be reviewed regularly to ensure appropriate coverage across all areas. • We have implemented a system for staff feedback to identify and address any gaps in social care provision.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The CNM hours have been reviewed, and the centre is working to restore appropriate clinical oversight in line with the SOP which reflects 1.7WTE to ensure compliance • The 2.7 multitasking attendants are rostered as per the SOP .	

• A review of rosters is ongoing to ensure alignment with the staffing structure outlined in the Statement of Purpose while maintaining safe and effective care delivery.
• A more robust auditing framework is being implemented to ensure that identified issues lead to actionable improvement plans with clear timelines for completion.
• A more robust auditing framework is being implemented to ensure that identified issues lead to actionable improvement plans with clear timelines for completion.
• A new system is being introduced to monitor the receipt and return of medications for respite residents, ensuring full accountability.
• Staff training is being enhanced to ensure audits are conducted effectively and that gaps in practice are promptly addressed through corrective action plans.
• Risk assessments are being revised to ensure they provide adequate protection to residents, including the implementation of a specific risk assessment and management plan for residents with Multidrug-Resistant Organisms (MDROs). This includes the provision of appropriate clinical waste bins.
• A full review of the risks associated with shared equipment is underway, and control measures will be implemented to mitigate potential hazards.
• Staff will receive additional training in risk assessment and management to enhance proactive identification and response to potential risks.
• A structured timeline has been established to complete outstanding training programs and ensure all policies are consistently applied in practice.
• Regular progress reviews are being conducted to track the implementation of the Quality Improvement Plan, ensuring accountability and sustained improvements.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

A full review of the Statement of Purpose has been initiated to ensure it aligns with the actual staffing structure and service delivery.
• The number of Whole-Time Equivalent (WTE) staff for healthcare assistants and multi-task attendants will be updated to provide a more transparent and accurate representation.
• Clarification will be provided regarding the WTE hours allocated to housekeeping and the laundry service to ensure consistency and accuracy.
• The WTE hours for the Respite Coordinator will be corrected to reflect the actual working hours.
• Going forward, a structured review process will be implemented to ensure the Statement of Purpose remains accurate and up to date, with periodic reviews aligned with any staffing or service delivery changes.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• We have arranged for a contractor to assess and repair the uneven paving to eliminate any trip hazards.
A dedicated gardening and maintenance plan have been implemented, which includes regular weeding and upkeep. Our maintenance team has already commenced work to address the overgrowth.
• To prevent recurrence, we have introduced a structured inspection and maintenance schedule for all outdoor areas. This will be monitored by our facilities team and reviewed as part of our internal audit process.
• We will ensure that residents can safely and comfortably enjoy the courtyard by seeking their feedback and incorporating their input into ongoing maintenance efforts.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

o Staff have been re-educated on the proper closure and disposal of sharps containers.
o Daily checks have been implemented to ensure compliance with safe disposal procedures.
2. Waste Segregation:
o Refresher training on waste segregation has been provided to all relevant staff.
o Additional signage has been placed in waste disposal areas to reinforce proper waste disposal practices.
o Routine audits have been enhanced to include checks on waste management compliance.
3. Storage in Sluice Room:
o Wheelchair footplates have been removed from the sluice room and relocated to a designated storage area.
o Staff have been instructed on the proper storage of non-clinical equipment to prevent contamination.
4. MDRO Resident Waste Management:
o A clinical waste bin has been provided in the resident's room.
o A review of all residents with infection control needs has been completed to ensure appropriate waste management measures are in place.
5. Cleaning of Communal Equipment:
o A documented cleaning schedule for all transfer and mobility equipment has been implemented.
o Staff have been trained on the importance of cleaning communal equipment between

resident use.
o A designated member of staff will be responsible for oversight and auditing of cleaning procedures.

Regulation 28: Fire precautions	Substantially Compliant

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

1.
o A full review of all fire doors has been conducted.
o Necessary repairs and replacements are scheduled with a certified fire safety contractor.
2. Ceiling Penetrations – Fire Stopping:
o A fire safety contractor has been engaged to seal all penetrations in the laundry and hot press store to ensure full fire compartmentation.
o Completion is scheduled with verification by a fire safety consultant.
3. Self-Closing Devices on Fire Doors:
o Adjustments have been made to the identified fire doors to ensure proper self-closing functionality.
o A routine maintenance program has been put in place to check fire door functionality on a scheduled basis.
4. Smoking Shelter – Heat Sensor & Call-Bell:
o A heat sensor has been ordered and will be installed by the 14th of March
o A call-bell system has been implemented to ensure residents can alert staff if needed.

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:

A full review of all care plans is underway to ensure clear differentiation between goals and interventions.
• Staff have received additional training on care plan documentation to enhance clarity and accuracy.
• Care plan audits have been introduced to monitor compliance and ensure continuous improvement.
• A care plan has now been developed for the resident with a colonised MDRO infection, incorporating infection prevention and control measures.

• A review of all residents with infection risks has been completed to ensure appropriate care plans are in place. • Infection prevention and control training has been reinforced with staff to ensure adherence to best practices.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Clarification of Goals and Interventions in Care Plans:
• A full review of all care plans is underway to ensure clear differentiation between goals and interventions.
• Staff have received additional training on care plan documentation to enhance clarity and accuracy.
• Care plan audits have been introduced to monitor compliance and ensure continuous improvement.
• Care Plan for Resident with Colonized MDRO Infection:
• A care plan has now been developed for the resident with a colonised MDRO infection, incorporating infection prevention and control measures.
• A review of all residents with infection risks has been completed to ensure appropriate care plans are in place.
• Infection prevention and control training has been reinforced with staff to ensure adherence to best practices.
• The Regional Support team completed a review of resident's records identifying gaps in recording resident's participation in activities. Findings were shared with the QCM and the DON and a documentation refresher training took place with the activity coordinator.
• The Organisation is recruiting for a second activity coordinator in order to ensure continuity of services provided.
• The DON is meeting regularly with the activity coordinator to provide support in planning residents activities and residents outings.

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.	Substantially Compliant	Yellow	15/04/2025
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.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	25/04/2025

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/03/2025
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	31/03/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the	Substantially Compliant	Yellow	28/03/2025

	Authority 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	25/04/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	25/04/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	25/04/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Not Compliant	Orange	31/03/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident	Substantially Compliant	Yellow	28/03/2025

	when these have been assessed in accordance with paragraph (2).			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	28/03/2025