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:	St Brigid's Hospital
Name of provider:	Health Service Executive
Address of centre:	Shaen, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	27 May 2025
Centre ID:	OSV-0000531
Fieldwork ID:	MON-0047182

About the designated centre

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

St. Brigid's Hospital is a two-storey premises and provides residential care for 23 male and female residents over 18 years of age with continuing care, dementia, palliative care and respite needs. Residents' accommodation is over two floors and accessed by a mechanical lift and stairs. Both floors are of similar design. Each unit has two day rooms, one of which is a designated dining area. There is also a second dining room on the ground floor. An oratory, hairdressing salon, sensory room and activity room are also provided for residents' use. In total, there are seven single bedrooms and eight twin bedrooms. Shared toilets and washing facilities are conveniently located off the circulating corridors on both floors. Residents have access to an enclosed garden accessible from the ground floor. Adequate parking is available at the front and side of the premises. Nursing care is provided on a 24-hour basis, and the provider employs nursing staff, care staff, catering, household and administration staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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
Tuesday 27 May 2025	08:30hrs to 16:20hrs	Niamh Moore	Lead

What residents told us and what inspectors observed

The purpose of this unannounced inspection was a safeguarding focused inspection completed within the designated centre St Brigid's Hospital. There was a calm environment within the centre and the inspector observed that residents' rights were supported by a team of staff who knew them well.

The inspector arrived to the centre on the morning of the inspection and was provided access to the reception area of the building. Upon entering the designated centre, the inspector completed the signing-in process and was met by a clinical nurse manager for the introductory meeting, who was the senior staff member on duty at that time. The inspector walked through the centre, and during this time was met by the person in charge. Many residents were spending time in their bedrooms and some were having their care needs attended to by staff, while others were in the communal areas of the centre.

St Brigid's Hospital is a nursing home which is registered to accommodate 23 residents and consists of three-storeys, named as the basement, ground and first floors. Residents' bedrooms were located on the ground and first floors, containing seven single bedrooms and eight twin bedrooms. Residents had access to en-suites or shared bathrooms. The ground floor accommodated female residents and the first floor accommodated male residents. Resident bedrooms were seen to be personalised with pictures, photographs and ornaments. The inspector was told by management that when resident's high support chairs were not in use, they were stored in the communal areas and not residents' bedrooms, as bedrooms lacked sufficient space and if the chairs were stored in their individual rooms, they would impact evacuation routes in an emergency. Residents reported that they were happy with their accommodation.

The residential floors contained day and dining spaces on each floor. The chapel was located on the ground floor and a priest attended the centre weekly to say mass. Ancillary facilitates such as the kitchen was located on the ground floor, with an external laundry room. The first floor was divided into two split levels with access to both areas provided by a lift. This area contained the hairdressing salon, staff break area, staff changing areas and storage. The basement area contained areas such as the boiler room and file storage. The inspector found that some areas of the premises required ongoing maintenance, impacting a homely environment. This will be further discussed within the report.

The inspector observed that staff and resident interactions were person-centred and respectful. Residents had access to television, phones, magazines and newspapers. Management told the inspector that broadband was available, however they were in the process of installing wireless internet, in line with the changes to the regulations. There was an activity schedule available and it was on display in the designated centre. The inspector noted that there was minimal activities throughout the day with hairdressing the only activity available in the morning, management

told the inspector they had activities identified as an area which required improvement within the centre. One resident told the inspector that they get bored during the day, particularly with limited activities except watching the television. Residents had access to advocacy services with posters of services on display on noticeboards in the centre.

The menu was on display on tables within the dining rooms. The inspector observed the lunch-time service on the day of the inspection. Residents were provided with a choice of meals which consisted of chicken maryland or roast ham, while dessert was apple tart and custard. The inspector found that where some residents had expressed other preferences, these were also provided for. There was also two choices for the tea-time meal. Condiments were available on tables and staff supported residents with their individual preferences for condiments and sauces on their meals. Meals were observed to be well presented, including for those on modified diets. There were enough staff available to assist residents with their meals, and this support was provided in a dignified manner. Residents reported to enjoy the meals.

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

Capacity and capability

The findings of this inspection were that it was evident that the management and staff had a commitment to providing person-centred care to residents. However, the current oversight and monitoring of safeguarding measures in place were not fully-effective.

The registered provider of St Brigid's Hospital is the Health Service Executive. The registered provider appointed a local management structure which included the general manager older person services for CHO8, a manager older person services and the person in charge.

The person in charge worked full-time in the centre, and were supported in their role by two clinical nurse managers grade 2, a clinical nurse manager grade 1, staff nurses, healthcare assistants, activity coordinator, multitask attendants who support with housekeeping and laundry, catering, administration and maintenance. There were a number of staff vacancies which were being covered by agency staff. The inspector observed that there were sufficient staff on duty to cater for the needs of residents, as evidenced by residents being provided with timely assistance to their needs in a respectful and unhurried manner.

The inspector also reviewed a sample of staff files and saw that Schedule 2 records were available and garda vetting in accordance with the National Vetting Bureau Act 2012 was in place prior to the staff members start date within the centre. The

registered provider also had a process to ensure that these disclosures were renewed every three years.

Schedule 5 written policies and procedures outlined and as required by the regulations were available, however some of these had not been reviewed in line with the changes to the regulations of March 2025.

Staff achieved compliance in safeguarding of vulnerable adults, however only 12 percent of staff had completed training in responsive behaviour (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The staff training policy dated May 2023 outlined that based on residents' needs additional training may be deemed mandatory. The inspector found that this training may support staff manage incidents of peer-to-peer safeguarding.

The provider had some arrangements in place to monitor and oversee safeguarding processes within the centre. For example, safeguarding was discussed at meetings such as management and residents' forums. Safeguarding incidents and complaints were logged on the appropriate systems. However, further enhancement of these oversight measures were required to ensure that all safeguarding incidents are appropriately investigated with appropriate actions in place to reduce incidents. This is further discussed under Regulation 23: Governance and Management.

Regulation 16: Training and staff development

87 percent of staff had received safeguarding training which was online. Staff training on induction included safeguarding processes and person-centred care.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider's own oversight mechanisms did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- Auditing was not always leading to quality improvements. Recent care plan audits did not review the use of restraints and therefore did not identify gaps in the management of restraint.
- Despite safeguarding concerns accounting for the highest incidents occurring within the centre, with some resident's being involved in multiple incidents, there was no evaluation or oversight of these incidents to review effectiveness of clinical practice and ensure the implementation of strategies to reduce the likelihood of re-occurrence.

While there was a 2024 annual review available which measured against the national standards and outlined actions to be taken in 2025, such as the environment to be more homely and pictorial menus to be developed. These actions did not outline the person responsible or timeframe to complete the action. In addition, there was no evidence that the annual review was prepared in consultation with residents and or their families.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Not all policies had been updated to ensure they reflected the regulations or changes within the service personnel. For example:

- The prevention, detection and response to abuse policy dated May 2023 referenced the requirement to notify the Chief Inspector within three working days, which had not been updated to reflect the new regulatory requirement of notifying the Chief Inspector within two working days.
- The procedure for the management of risks and protection of residents from harm policy dated May 2023 did not reflect the current complaints officer.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents received a high standard of care from staff who were familiar with and were responsive to their needs. However on this inspection, improvements were required in restraint use, safeguarding, residents' rights, and the premises, as described and detailed under the relevant regulations below.

A selection of care plans were reviewed on the day of inspection. Validated assessment tools were used to guide the development of care plans. The inspector saw care plans were mostly updated at four monthly intervals in line with the regulations. Overall the standard of care plans relating to personal care, social and communication needs were good. Notwithstanding these good findings, information relating to the provision of care planning for restraint and safeguarding are reflected under Regulation 7: Managing behaviour that is challenging and Regulation 8: Protection.

The registered provider's policy on the use of restraint effective from September 2023 had not been fully implemented in three records reviewed. This policy stated that each resident will have a restrictive practice assessment prior to restraint use and its use will be for the shortest duration possible and monitored on an ongoing

basis. In addition, in line with National Policy *Towards a Restraint Free Environment in Nursing Homes*, there was no alternative trialled to ensure that the least restrictive measure was in place.

The registered provider was a pension agent for five residents. The inspector viewed documentation and saw the registered provider had a separate client account in place to safeguard residents' finances with records of all transactions. Statements were provided to residents every three months. In addition, there were safe systems in place to ensure any petty cash held on site was available for residents and appropriately documented as per the registered provider's policy.

A review of a sample of safeguarding incidents were seen to have been referred to the appropriate external agencies, for example the safeguarding and protection team. While it was evident that overall residents were supported within the centre, safeguarding documentation required further oversight. Particularly to the updating of safeguarding care plans to ensure staff were informed of the safeguarding measures in place to promote and protect residents' health and wellbeing.

Staff upheld residents' rights at all times of care provision. They were observed to be patient and kind to residents, and residents reported overall being happy living in the centre. Residents had access to newspapers and magazines, and access to wireless internet was in progress. An activity schedule outlined activities available Monday to Sunday, and while the inspector saw there was some small group engagements occurring during the inspection, many residents were observed watching the television. One resident told the inspector that they were bored of watching the television.

Staff were observed to appropriately communicate with residents who had communication difficulties, including affording appropriate time to the resident to express themselves and not hurry them.

Efforts were seen to ensure the centre was decorated and homely. However, there was poor storage practices identified and there was ineffective oversight of maintenance which impacted the environment for residents. This is further discussed under Regulation 17: Premises.

Regulation 10: Communication difficulties

Assessments had been completed of the communication needs of residents. Where there was an identified specialist communication requirement, these were recorded in their care plan.

Judgment: Compliant

Regulation 17: Premises

The inspector found that some action was required to ensure the premises conformed to all of the matters set out in Schedule 6. For example:

- A storage area in the older part of the premises was seen to be in a poor state of repair. For example, the window was boarded up but wind was coming through and there was damage to some of the walls where the bricks were missing.
- Wear and tear to paintwork was observed on door frames, radiators and to residents' equipment which would not allow for effective cleaning.
- Wear and tear was observed to one area of flooring on a corridor. The damage visible on this floor would not allow for effective cleaning in this area.
- Holes were visible to the wall in a bathroom on the first floor.
- The designated smoking area required further maintenance, there was substantial cobwebs observed and the external roofing made of transparent material was noticeably dirty.
- Emergency call facilities were not accessible in every area used by residents. The designated smoking facility did not have an emergency call bell to enable residents to call for support if required.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care records on areas such as personal care, social needs and communication were seen to be detailed and person-centred to sufficiently guide care. The monitoring and updating of assessments and care plans was evident.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Not all staff had access to relevant training on responsive behaviours. In addition, while individual de-escalation measures to relax and reassure residents were detailed in care plans, records showed that these specific measures were not always trialled with residents during incidents of responsive behaviours.

The inspector reviewed three care plans in relation to physical and environmental restraints. These care plans did not provide sufficient detail to ensure the restrictive practice was used in line with the residents' current assessed needs and for the least time required. For example, one resident had a restraint in place due to a history of

unexplained absence prior to their admission to the nursing home, there was no documented evidence of alternatives trailed to ensure the least restrictive measure was in place.

Judgment: Not compliant

Regulation 8: Protection

All reasonable measures to protect residents from abuse had not been taken. For example:

- One allegation of abuse had not been appropriately investigated, and therefore assurances were not provided that all sufficient controls were in place to safeguard residents.
- For known safeguarding needs, safeguarding care plans were generic and referred to the overall safeguarding policy within the centre instead of specific measures in place to safeguard the individual residents.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector found that not all residents had opportunities to participate in activities. There was limited activities occurring on the day of the inspection, activities were seen to occur in the afternoon, however visiting the hairdresser was the only activity scheduled for the morning, meaning there was no activity for those residents who did not wish to have their hair done. This area for improvement had also been identified by the registered provider however limited action had been taken to address this. It was also a repeat finding from the last inspection.

While residents' meetings were held every three months to enable residents opportunities to feedback on the service. The registered provider's compliance plan following the inspection in July 2024, outlined a satisfaction survey would be completed with residents and their nominated support person, however there were no records to evidence this had occurred.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Brigid's Hospital OSV-0000531

Inspection ID: MON-0047182

Date of inspection: 27/05/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Care plan audits will include reviewing the use of restraints and will identify gaps in the management of restraint. • Review of the Restraint Audit tool with the Nursing Practice Development Co-ordinator Older Persons Service to ensure best evidenced practice and quality improvements will be undertaken. • The PIC will evaluate and oversee all safeguarding incidents to review effectiveness of clinical practice and ensure the implementation of strategies to reduce the likelihood of re-occurrence and to ensure all Safeguarding plans are specific to individual residents. • A storage area in the older part of the premises has now received funding from HSE Estates to upgrade the room. • All matters identified in relation to painting, maintenance, upgrades and repairs in the premises will be completed. The 2024 annual review was discussed with the residents at their Resident's Association meeting which was facilated on the 12th June 2025. The person responsible and timeframes for corrective action or recommendations for improvement will be assigned and detailed within the report. Feedback from residents and their representatives will be included in future annual review reports.	
Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: All policies will be updated to ensure they reflect the regulations or changes within the service personnel. • The prevention, detection and response to abuse policy dated May 2023 will be updated to reflect the new regulatory requirement of notifying the Chief Inspector within two working days. • The procedure for the management of risks and protection of residents from harm policy dated May 2023 will be updated to reflect the current complaints officer.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A storage area in the older part of the premises has now received funding from HSE Estates to upgrade the room. • A HSE painter is scheduled to repaint all areas idenitified where paint work is not easily cleanable. • Damaged floor covering will be repaired to ensure it is safe and easily cleanable. • HSE Maintenance to repair any deficit to walls in bathroom. • External roofing area will be cleaned and maintained in a good state of repair. • Emergency call bell to be installed in designated smoking area. This has also been highlighted in the Safety Statement and Risk Register which is being updated at present.	
Regulation 7: Managing behaviour that is challenging	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: All staff will have access to relevant training on responsive behaviours starting in September. Training will include a 2-day workshop, which will also cover positive support plans. Day 1 - Values and Communication Day 2 - A Person-Centred Focus on Care Planning. A half day training in managing behaviours and de-escalation techniques will also be available in September, October and November 2025.	

Staff will be instructed to record what specific measures were trialled to de-escalate the incident of responsive behaviour and the measures used to relax and reassure the residents as documented in the individuals care plans.
In relation to physical and environmental restraints, care plans will be reviewed to ensure that the individual care plan will provide sufficient detail to ensure the restrictive practice is used in line with the residents' current assessed needs and for the least time required. Alternatives trailed to ensure the least restrictive measure to be used will be documented.
Independent audits of care plans will be undertaken by the Nursing Practice Development Co-ordinator Older Persons Service.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All reasonable measures to protect residents from abuse will be taken. For example:
• The allegation of abuse had been fully investigated, followed up and a report written which includes a Safeguarding plan. A copy of the report is available on request.
• Safeguarding care plans will be reviewed on an individual basis to inform staff of specific measures to be put in place to safeguard the individual residents.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
An activities core group of staff will be established who will embrace a robust Activity programme supported by management. Each resident's PAL assessment will be reviewed and updated to determine residents' interest and hobbies and individual activity care plans developed.
A residents' meeting was held on the 12th July which enabled the residents opportunities to feedback on the service. Satisfaction surveys are in progress.
Family members will be contacted in relation to participating in the Resident's Forum.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/08/2025
Regulation 23(1)(f)	The registered provider shall ensure that the review referred to in subparagraph (e) is prepared in consultation with	Substantially Compliant	Yellow	31/08/2025

	residents and their families.			
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e).	Substantially Compliant	Yellow	31/07/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	15/07/2025
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	30/11/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on	Not Compliant	Orange	30/06/2025

	the website of the Department of Health from time to time.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	20/06/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	15/08/2025
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	31/07/2025