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:	Aras Mhathair Phoil
Name of provider:	Health Service Executive
Address of centre:	Knockroe, Castlerea, Roscommon
Type of inspection:	Unannounced
Date of inspection:	10 June 2025
Centre ID:	OSV-0000652
Fieldwork ID:	MON-0044899

About the designated centre

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

The designated centre provides 24-hour nursing care to 24 male and female residents over 18 years of age, who require long-term and short-term care including dementia care, convalescence, palliative care and psychiatry of old age. The centre premises is a single story building. Accommodation consists of 12 single and six twin bedrooms. Communal facilities included a dining room, a sitting room, a sunroom, an oratory, a visitors room and a safe internal courtyard. There are two assisted bathrooms each with a bath with chair hoist, wash hand basin and toilet facilities, one assisted shower room with easy accessible shower, wash hand basin and toilet facilities. An accessible toilet is located close to the sitting rooms and the dining room. The provider states that the centre's philosophy of care is to embrace ageing and place the older person at the centre of all decisions in relation to the provision of the residential service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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 10 June 2025	09:10hrs to 18:00hrs	Gordon Ellis	Lead
Tuesday 10 June 2025	09:10hrs to 18:00hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

Inspectors met with residents and staff, and spoke with four residents and two visitors in more detail to gain insight into their experience of living and visiting Arus Mhathair Phoil. Those spoken to were positive about their experience of living in this centre, and were complimentary of the staff and management. One resident informed the inspector that 'I'm very happy and this place couldn't be better'. Another resident was equally complimentary and said 'staff couldn't do more for you'. Other feedback given to the inspectors was that the food was generally good with choices available but two residents did mention they would like different choices at suppertime. Similarly, three of the residents and one of the visitors mentioned that they would like more variety with activities and the option of visiting places external to the centre. Residents and visitors told the inspectors that staff were alert to their needs and there usually was no delays with staff answering their call bells. However, a number of actions were required to bring the centre into compliance with the regulations, in order to ensure the quality and safety of resident care.

Bedroom accommodation was provided in 12 single and six twin bedrooms. The twin bedrooms had full en-suite facilities. The single bedrooms were without ensuites. Storage seen in double room ensuites were not adequate for two residents sharing. Toiletries not marked with the residents name, were seen in these shared ensuites, shared bathrooms and showers, this could lead to cross contamination and lack of resident dignity.

All bedrooms were fitted with a ceiling hoist unit and contained furniture and fixtures to meet residents' needs. The inspector observed that the single bedrooms were small, however residents spoken with said they had sufficient storage space for their clothing and personal possessions. There was a variety of communal rooms available for residents and the inspector observed good usage of these rooms.

Overall the general environment, residents' bedrooms, communal areas and toilets, seen by the inspectors appeared visibly clean and well maintained. The centre was found to be well-lit and warm. The bedrooms seen by the inspectors were personalised with photographs, ornaments and other personal memorabilia. Televisions and call bells were provided in all bedrooms seen.

Residents had easy access to a secure internal courtyard, which was paved and had seating areas for residents and their visitors to use and enjoy the garden in the fine weather.

Storage space was extremely limited throughout the centre, which resulted in the inappropriate storage of equipment and supplies throughout many of the unoccupied bedrooms and bathrooms. For example, one empty bedroom was used to store hoists, wheel chairs, walking frames, foot stools and chairs. Another had 5

mattresses stored on a bed. Limited storage is a repeat finding from the last two inspection.

The centre provided a laundry service for residents and larger items such as sheets and towels were sent to an external laundry provider. Residents whom inspectors spoke with were happy with the laundry service and there were no reports of items of clothing going missing. The infrastructure of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process. There were commercial grade washing machines within this room. However, there was also a domestic style washing machine, to launder mops and cloths. Compliance with thermal disinfection temperatures could not be assured using this type of washing machine. There was also, inappropriate storage of clean linen, pressure care cushions and crash mats seen in this room, which may become contaminated whilst laundry procedures are taking place.

Staff also had access to a dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment and a sluice room for the reprocessing of bedpans, urinals and commodes. Both room were fit for purpose and clean.

Hand hygiene facilities in parts of the centre supported effective hand hygiene practices. Conveniently located hand wash sinks and alcohol-based product dispensers along corridors facilitated staff compliance with hand hygiene requirements. However, in all of the single bedrooms there was no hand washing sink or alcohol gel at the point of care for staff to clean their hands. Clinical hand washing sinks seen all complied with current recommended specifications.

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 had a specific focus on the provider's compliance with fire safety and infection prevention and control oversight, practices and processes.

The provider had submitted a compliance plan response to the Chief Inspector following the Nov 2024 inspection with time lines provided of when the provider expected to be in compliance with the regulations. On the day of this inspection inspectors found that the provider had not completed some of these actions including governance and oversight, audits and their resulting action plans, lack of storage, clinical nurse manager post and reliance on agency use.

A new clinical nurse manager post was in place since August 2024. This had helped to strengthen the clinical management structure in the centre. However, this post was again vacant since May, 2025 and this meant there was not suitable deputising arrangements in place for the absence of the person in charge. There continues a high usage of agency staff for cleaning, residents' activities and catering roles within

the centre. The inspectors were told recruitment was being progressed however, there was no clear time frames for staff appointments to be completed. This was not a sustainable staffing model and did not ensure continuity of care for the residents and is further discussed under Regulation 23: Governance and Management.

There were management systems occurring such as clinical governance meetings, staff meetings and residents meetings. The quality and safety of care was being monitored through a schedule of audits including infection prevention and control. Nonetheless, the audit system in place was not effective to support identification of risk and deficits in the quality and safety of the service. Quality improvement plans were not developed in line with the audit findings or meetings. For example, a safe injection practice audit was completed in Feb 2025 and it noted that staff needed training in safety engineered sharps devices to minimise the risk of needle stick injury. This was not done and the provider had not substituted traditional needles with safety engineered sharps devices. Similarly, an IPC audit in Oct, 2024 noted there was no dedicated area to store laundry when clean, and this was still the case.

The provider had carried out extensive fire safety works identified in a Fire Safety Risk Assessment and had completed fire safety commitments from a previous inspection. However, improvements were required in the day-to-day arrangements of fire safety, servicing and checking of some building services, maintenance of escape routes and minor maintenance issues to some fire doors. These are outlined in detail under Regulation 28: Fire Precautions.

An annual review of the quality and safety of care delivered to residents had not been completed for 2024.

Staff meeting records seen dated 25th February 2025 discussed lack of storage and how staff were not to use vacant bedrooms for storage. However, this action was not in place as multiple vacant bedrooms were being used for storage on the day of inspection.

The centre did not have up to date IPC policies which covered aspects of standard precautions and transmission-based precautions. Hand hygiene and IPC polices seen by the inspectors were in need of review from February 2022 and February 2023 respectively. A review of training records indicated that all not all staff were up to date with IPC training in line with their role within the centre. 6 out of 11 nurses and 8 and 12 health care assistants were not in date. The inspectors saw reference to this in a staff meeting dated 30th May 2025 reminding staff to complete. The minutes of these meetings were also missing an action plan to follow up and assign responsibility to.

The person in charge had recently supported a staff member to complete the Infection prevention and control link nurse training with the Health Service Executive (HSE), helping to focus and structure compliance with infection prevention and antimicrobial stewardship practices within the centre. The infection control link practitioner currently did not have protected hours on the staffing rota to complete this role.

The centre had managed a respiratory outbreak last year and had an outbreak learning report completed. Systems were in place to monitor the vaccination status of residents and staff and to encourage vaccination, to the greatest extent practical.

The provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists and colour-coded cloths and mops to reduce the chance of cross infection. Housekeeping staff spoken with had a good understanding of the cleaning and disinfection needs of the centre. There was one housekeeper on duty seven days per week, which was in accordance with the centre's statement of purpose and the centre was seen to be clean.

The provider had implemented a number of water safety controls in the centres water supply. For example, unused outlets and showers were run weekly. However, documentation was not available to confirm that the hot and cold water supply was routinely tested for *Legionella* to monitor the effectiveness of controls.

Surveillance of multi-drug resistant organism (MDRO) colonisation was also undertaken and recorded. Staff were aware that a small number of residents were colonised with MDROs. Residents that had been identified as being colonised with MDROs were appropriately cared for with standard infection control precautions. The appropriate care plans were in place, however, more detail was required in the care plans reviewed by the inspectors to direct staff in the care of residents with MDRO's.

Regulation 15: Staffing

Based on a review of the worked and planned rosters and from speaking with residents and visitors, sufficient staff of an appropriate skill mix were on duty each day to meet the assessed needs of the residents. Call-bells were seen to be answered quickly, and staff were available to assist residents with their needs. There was at least two registered nurses on duty at all times.

There were sufficient staff resources to maintain the cleanliness of the centre. There was one housekeeping staff on duty on the day of the inspection as per the statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. A system for tracking staff training and records was made available to the inspector on the day of the inspection, however, these training records indicated that all not all staff were up to

date with infection prevention and control training in line with their role within the centre.

The centre did not have up to date local or national infection prevention and control policies.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems required strengthening to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. For example:

- The management structure in place on the day of the inspection did not correlate with the management structure outlined in the statement of purpose (SOP) submitted as part of the registration of the centre. The SOP against which the centre is currently registered outlined a management structure that included one whole time equivalent (WTE) PIC and one CNM. On the day of the inspection it was found that there was no CNM.on the roster. There was no suitable arrangements in place for the absence of the person in charge.
- While a range of audits were being completed issues identified had not been fully addressed and actioned. For example, the infection control audits did not identify inappropriate storage and unidentified (no resident name or ID number) hoist slings found in the centre. Additionally, there was not always a time bound action plan associated with each audit to identify who was responsible for addressing the required actions or to confirm that the action had been completed.
- The staff model required review.The current practice of using agency staff to replace vacant positions such as in cleaning, social activities and catering staff positions continued to pose a risk to the safety of residents and the quality of care delivered to them. A health care assistant had been allocated to deliver activities over a 3-4 day week as there were no dedicated members of the activities team in place.
- The water safety legionella management programme required review as while some risk controls were in place, water samples were not routinely taken and tested to assess the effectiveness of the local program.
- An annual report of the quality and safety of care delivered to residents had not been completed for 2024.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of records found that the person in charge submitted notifications to the Chief Inspector in accordance with the requirements of the regulations.

Judgment: Compliant

Quality and safety

This inspection found that the management of fire safety, as described in the capacity and capability section of this report, was of a good standard to ensure the safety of residents, staff and visitors.

Due to the findings of previous inspections, a restrictive condition in regards to fire safety works had been placed on the registered provider. This outlined that no new residents may be admitted to the designed centre until the provider had complete all red and orange risks identified in the providers own fire safety risk assessment. The inspectors concluded that all fire risks had been completed and final sign-off had been obtained from the providers' competent fire consultant. Furthermore, the provider had taken action in regards to fulfilling their commitments outlined in a previous inspection in respect of Regulation 28: Fire Precautions.

Notwithstanding this, improvements were required in respect of the day-to-day arrangements of fire safety, servicing and checking of some building services, maintenance of escape routes and some minor fire doors.

Staff training records were reviewed and demonstrated all staff up-to-date with fire safety training. Staff spoken with demonstrated a good knowledge of the evacuation procedure in place and had trained for progressive horizontal evacuation, and vertical evacuation. Staff were able to demonstrate to the inspector the location of the largest compartment in the centre and where the fire assembly points was located.

Comprehensive personal emergency evacuation plans (PEEPS) were in place for all residents and were kept under review. The inspectors reviewed the fire safety register and noted that it was well organised and up-to-date. The in-house periodic fire safety checks were being completed and logged in the register as required. An external fire door company had been appointed to carryout out quarterly serving and maintenance of all fire doors. However, checks to fire doors during these interim periods were not being completed or recorded by staff.

There was a fire safety management plan and emergency fire action plan in place. These were found to be comprehensive and informed robust fire safety management in the centre.

Service records were available for the various fire safety and building services and these were all up to date. However records for the checking of fire evacuation

equipment and the servicing of laundry machinery were not available from the provider.

Residents spoken with told the inspector that they received a good standard of care and support which ensured that they felt safe. There was a person-centred approach to care, and residents' well being and independence was promoted. However, the provider did not manage the ongoing risk of infection to the residents.

There were no visiting restrictions in place and there were suitable rooms for residents to have visitors in private.

Residents received ongoing support from their General Practitioner's (GP), however, inspectors were informed it was not always the case that residents were regularly reviewed. Allied health care professionals including physiotherapists, occupational therapists, dieticians and speech and language therapists (SALT) were available to residents on referral and the centre had a dedicated physiotherapist two days per week.

An infection prevention and control assessment formed part of the pre-admission records. These assessments were used to develop care plans that were seen to person-centred and reviewed regularly as required. Resident care plans were accessible on an paper based system, this now included the National Transfer Document which is used when residents are moved to acute care.

The inspectors also identified some examples of good antimicrobial stewardship. For example, the volume of antibiotic use was monitored each month. There was a low level of prophylactic antibiotic use within the centre, which is good practice. Staff also were engaging with the "skip the dip" campaign which aimed to prevent the inappropriate use of dipstick urine testing that can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance.

Staff were observed to apply standard precautions to protect against exposure to blood and body substances during handling of sharps, waste and used linen. Waste and used linen and laundry was segregated in line with best practice guidelines. Colour coded laundry trolleys and bags were brought to the point of care to collect used laundry and linen. Appropriate use of personal protective equipment (PPE) was observed and all staff were bare below the elbow to facilitate effective hand hygiene practices. Notwithstanding, these good practices in IPC there were some areas that needed improvement. For example, the provision of alcohol gel at the point of care (resident bedrooms) was not sufficient. Inspectors noted that disposable privacy curtains were in use which were dated when they were hung. Many of them were in place since 2022 and 2023 which posed a risk of infection for residents.

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 throughout the centre.

Judgment: Compliant

Regulation 17: Premises

The premises was not maintained in line with regulations with regards to suitable storage. For example;

- Limited storage space was provided.Vacant bedrooms and bathrooms were used all over the centre for storage of wheelchairs, hoists and other assistive equipment. This reduced space available in these rooms for residents to safely move around these rooms and posed a risk of cross infection. This is a repeated finding from the last two inspections.
- Double room ensuites did not provide suitable storage for resident toiletries leading to risk of cross infection.
- All bedroom privacy curtains were of the disposable type and had not been changed in some cases since 2022, which posed a risk of infection.
- Signs of water ingress and cracking on a ceiling along one corridor and in a laundry room were noted, which were in need of repair and decoration.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

Where a resident was temporarily absent from the designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon a resident's return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy and risk register in place which identified hazards and control measures for the specific risks outlined in the regulations.

Arrangements for the investigation and learning from serious incidents were in place and outlined in the policy.

Judgment: Compliant

Regulation 27: Infection control

The provider was not in full compliance with Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018). For example;

- The provider had not substituted traditional unprotected sharps/needles with a safer sharps devices that incorporates a mechanism to prevent or minimise the risk of accidental injury.
- Alcohol hand rub was not available at the point of care for each resident. This meant that there was an increased risk of the spread of infection.
- Unlabelled toiletries were observed in resident's rooms, bathrooms and ensuite cupboards which poses a risk of cross contamination if multiple residents are using these products.
- Inspectors observed unlabelled toileting and handling hoist slings stored in bathrooms and vacant bedrooms, which is a risk of cross contamination and manual handing risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had taken adequate precautions to ensure that residents were protected from the risk of fire. The provider had completed commitments from the previous inspection and the commitments outlined in their restrictive condition. Notwithstanding this, improvements were required to comply with of the requirements of some regulations.

Day-to-day arrangements in place in the centre were not fully implemented to provide adequate precautions against the risk of fire. For example;

- Oxygen concentrators were stored in a clinical room. Appropriate signage was missing outside this room to indicate the storage of oxygen.
- A build-up of lint was found in a dryer in the laundry room and a schedule for removing lint on a regular basis was not available from the provider. This created a potential fire risk as dryer lint is flammable.

- Records were not available from the provider for the checking of fire evacuation equipment such as evacuation ski sheets or evacuation aids to ensure they were fitted correctly, in good working order and ready for use.
- An evacuation chair was found stored in a room instead of being fitted in close proximity to the fire exit at the top of the external staircase. This could delay an evacuation in a fire emergency.
- Laundry equipment both commercial and domestic grade were in use in the laundry room. Servicing and maintenance records were not available from the provider for the regular servicing of laundry equipment and machinery. This had been identified in October 2024 audits and escalated by staff. However it had not been acted upon by the provider.

Arrangements for the maintenance of the means of escape, building fabric and building services were not fully implemented. For example;

- The means of escape and fire exits throughout the designated centre were free from obstruction and clutter free. Notwithstanding this, the inspectors noted an area at the bottom of an external escape staircase was cluttered with laundry trolleys and wheelchairs. This could potentially impede an escape route in the event of a fire.
- The majority of fire doors throughout the centre were maintained to a good standard and fit for purpose. However, some minor deficiencies were observed. Three sets of cross corridor fire doors did not fully align when tested and a gap between the vertical stiles of one set of double fire doors was noted in the dining room.
- A ceiling in a store room adjacent to a dayroom had signs of cracking and a small hole through the fire resistant ceiling that required fire sealing
- A fire register, checks and audits were being completed on a daily, weekly and monthly basis. Fire doors were being serviced by an external company every quarter. However, staff were not carryout checks to identify shortcomings or faults to fire doors in the interim periods.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The appropriate care plans were in place, however, more detail was required in the care plans reviewed by the inspector to direct staff in the care of residents with MDRO's.

Judgment: Substantially compliant

Regulation 6: Health care

Records showed that residents had access to medical treatment and expertise in line with their assessed needs, which included access to physiotherapy, tissue viability and dieticians as required. However, some residents were not regularly reviewed by their GP's.

A number of antimicrobial stewardship measures had been implemented to ensure antimicrobial medications were appropriately prescribed, dispensed, administered, used and disposed of to reduce the risk of antimicrobial resistance.. Infection prevention measures were targeted towards the most common infections reported. Staff were knowledgeable about the national "Skip the Dip" campaign that reduces the use of urine dipsticks as a tool to indicate if a resident had a urine infection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' meetings were held regularly to give the residents a voice and to be involved in the running of the centre with their views and suggestions. Residents had access to televisions, telephones and newspapers and were supported to avail of advocacy services as they wished.

Residents did not have access to opportunities to participate in meaningful activities over a 7 day period, due to staff leave and the inability to recruit into this role. A health care assistant had been allocated to deliver activities over a 3-4 day week as there were no dedicated members of the activities team in place.

Residents spoken to expressed that while the food was generally good with choices available , two residents did mention they would like different choices at suppertime.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	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	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Aras Mhathair Phoil OSV-0000652

Inspection ID: MON-0044899

Date of inspection: 10/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Mandatory training attendance for hand hygiene has shown marked improvement, now standing at 88% for clinical staff. Efforts are ongoing to achieve and maintain the HSE target of 90%. • PIC to ensure up to date local Infection Prevention and Control policies are available in the centre. Assistance has also been sought from Infection Prevention and Control Team.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A CNM has accepted the position and we await confirmation from recruitment to when a start date agreed. • Going forward a time bound action plan associated with each audit will be put in place and this will identify who is responsible to confirm that required actions have been closed out • All vacant posts have been submitted to senior management for sign off, as staff are employed agency will reduce. • Following inspection, water samples were collected for Legionella on 25/06/2025. Report of 'Not Detected' was provided to the unit on 10/07/2025. • The annual report of the quality and safety of care delivered to residents will be completed by August 15th.	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Maintenance have been asked to look at providing an external storage facility.
• The storage for resident toiletries will be segregated to minimize risk of cross infection.
• Disposable bedroom privacy curtains have been ordered to replace current curtains. We have now ordered extra stock to ensure timely replacement of curtains when required.
• Ceilings in the laundry and the hallways are being repaired by the maintenance department.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Unprotected sharps/needles is now replaced with safer sharps devices that incorporates a mechanism to prevent or minimise the risk of accidental injury.

• Alcohol hand rub is available in all corridor. PIC has liaised with IPC team to do a walk around of the unit on 15/07/2025 and provide further guidance to ensure compliance with the regulation.
• PIC to liaise with maintenance department to create a partition in the toilet cabinet. This would provide dedicated space for residents in twin sharing to store their toiletries. PIC to liaise with Health Care Assistants to ensure residents toiletries are labelled.
• PIC to work with Health Care Assistants to ensure all toileting and handling hoists are labelled and stored in residents own room to reduce the risk of cross contamination.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Signage to be installed by maintenance where Oxygen concentrators were stored in a clinical room.
• Schedule for removing build-up of lint from the dryer is now in place and laundry staff will comply with the same.
• Maintenance Department has now fitted the evacuation chair in close proximity to the

fire exit at the top of the external staircase. PIC to ensure following installation chair is not removed from the location.
• An agreement has been reached with an external contractor to carry out an annual service of all Laundry equipment's and the recommendations.
• Signage is in place informing staff at the bottom of external escape staircase to keep this area free from storage containers as it is fire escape route. PIC or Nurse In-Charge to do walk around every day to ensure the same.
• Maintenance Carpenter will address the issues highlighted about the three sets of cross corridor fire doors and that of gap between the vertical siles of one set of double fire doors in the dining room. Once actioned the same to recorded in Fire Safety Register.
• Maintenance Department have already initiated works on the structural issues noted in the ceiling of the store room.
• PIC to assign person as prescribed in the Fire Safety register to carry out checks to the fire doors.
• PIC to assign person for checking of fire evacuation equipment such as ski sheets and evacuation aids are in good working order, fitted correctly and ready for use. This would be included as part of Fire Safety training.

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:
• Care plan in more detail will be developed for residents with MDRO's.
• PIC have also liaised with Infection Prevention and Control Clinical Nurse Specialist for support and guidance to ensure compliance with this regulation.
• PIC has liaised with an external agency to provide Care Plan training and is awaiting confirmation for a date.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Each Resident has access to GP services and we will continue to engage with resident's GP to ensure timely review.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• PIC had approached framework and off framework agencies to recruit activity coordinator. A candidate has been shortlisted and we are awaiting on a start date.
• Approximately 8 music sessions per month has been arranged with external agency to promote social interaction.
• All residents are informed of menu for the supper time well in advance. Should any resident wishes to order differently it is informed to and accommodated by Chef.

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	29/08/2025
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	19/09/2025
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	29/08/2025
Regulation 23(1)(b)	The registered provider shall ensure that there	Not Compliant	Orange	29/08/2025

	is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Not Compliant	Orange	29/08/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	12/09/2025
Regulation 23(1)(e)	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	Not Compliant	Orange	15/08/2025

	under section 10 of the Act.			
Regulation 23(1)(f)	The registered provider shall ensure that the review referred to in subparagraph (e) is prepared in consultation with residents and their families.	Not Compliant	Orange	15/08/2025
Regulation 23(1)(g)	The registered provider shall ensure that a copy of the review referred to in subparagraph (e) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	15/08/2025
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).	Not Compliant	Orange	29/08/2025
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.	Substantially Compliant	Yellow	29/08/2025
Regulation 27(c)	The registered provider shall ensure that staff	Substantially Compliant	Yellow	29/08/2025

	receive suitable training on infection prevention and control.			
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	29/08/2025
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	12/09/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	15/08/2025
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Substantially Compliant	Yellow	12/09/2025

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	01/09/2025