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:	Sacred Heart Hospital & Care Home
Name of provider:	Health Service Executive
Address of centre:	Golf Links Road, Roscommon
Type of inspection:	Unannounced
Date of inspection:	06 February 2025
Centre ID:	OSV-0000654
Fieldwork ID:	MON-0044697

About the designated centre

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

The Sacred Heart Hospital provides residential, respite and rehabilitation services to sixty two adults. The centre is organised into four units. St Catherine's unit has 32 beds and includes one palliative care suite. Our Lady's unit provides care for 13 residents who require long term care. St Michael's provide 17 beds, 14 long term and 3 beds allocated for respite care. All units are self contained and have a main sitting and dining area and other smaller seating areas. There are a number of communal bathrooms and toilets on each unit. St Catherine's has four single en-suite rooms. There are several enclosed gardens that are accessible from each unit and that have been cultivated to provide interest for residents. The centre is located close to Roscommon town and local amenities. There are allied health professionals on site and a physiotherapy suite and an occupational therapy room are accessible to residents. An activities therapy team organise and provide the daily activities programme.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 6 February 2025	09:00hrs to 16:00hrs	Michael Dunne	Lead
Friday 7 February 2025	09:30hrs to 16:00hrs	Michael Dunne	Lead
Friday 7 February 2025	09:30hrs to 16:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Residents living in this centre were supported to enjoy a good quality of life. There was evidence to show that residents were offered choice in key aspects of their care. The inspectors found that residents were supported and facilitated to choose how and where they spent their day in accordance with their preference.

This was an unannounced inspection carried out over two days by an inspector of social services, who was accompanied by a second inspector on day two of the inspection. Following, an introductory meeting with the person in charge, on day one the inspector completed a walk about of the designated centre. This provided an opportunity for the inspector to meet with residents and observe their day to day routines. Over the course of the inspection, residents who expressed a view, described the service as "great". One resident said that they were "very happy with the care and support provided" and that they felt confident that staff would be there when they needed them.

Residents were overwhelmingly positive about the staff who provided their care. Staff were observed to be respectful and empathetic with residents during the inspection. Residents were observed to be given time to understand what staff were saying to them. Residents said that they felt safe in the centre and, that if they did have a problem or a concern they could raise it with any member of the staff team.

Since the last inspection in February 2024, the provider was found to have continued with their redevelopment programme of the designated centre which had included the removal of St Josephs unit to make way for the construction of a new 50 bedded unit which is currently underway. The provider had ensured that measures were in place to minimise any disruption to the existing residents from the construction process. The provider was monitoring construction hours and securing the building site to maintain resident safety. In addition, the provider ensured that residents were kept updated on the works progress with the new unit through monthly site meetings.

The centre was a single story building with resident's accommodation located in three separate units, St Michael's unit, Our Ladies unit and St Catherine's unit with each unit having their own sitting room and dining room facility. Multi-occupancy bedrooms were well organised to ensure that residents were able to sit out within their own private area. In addition residents had unrestricted access to their storage facilities. All resident accommodation observed on this inspection was found to be tastefully decorated and personalised by the residents living in those rooms.

Communal facilities were also well-maintained. Corridors were bright and adorned with colourful pictures. Fresh flowers were observed in all of the units inspected and provided a homely welcoming atmosphere.There was a maintenance schedule in

place to maintain the premises, some improvements to this schedule were identified on inspection and are discussed under Regulation 17:Premises.

There was a schedule of activities available for residents seven days a week. The schedule was advertised in all of the units and corridors. The activity schedule was designed in conjunction with the residents to meet their varied interests and capacities. There were numerous initiatives in place to support residents to maintain links with the local community and residents were observed being supported to visit the facilities in the town. Residents were also supported with their educational needs.

Inspectors observed the numerous activities being provided on the days of the inspection, from arts and crafts, to a music session, to supporting resident attend the hairdresser. The local priest attended to celebrate mass in St Catherine unit, and also visited residents who chose to remain in their bedrooms. Some residents told the inspectors that they wished to spend quiet time in their bedrooms or in other quiet areas rather than engage in group sessions. Several residents were observed spending their time watching television or using social media on their phones or computer tablets. Residents went on to say that staff respected their preference not to participate in the group activities and supported them to spend their time quietly as they wished

Residents were seen being supported to have their meals in their designated dining rooms. The service was well-organised by the staff team. Food was transported to the dining rooms by means of a hot trolley which maintained the correct temperature for the meals served to residents. Residents who required assistance with their eating and drinking were supported in a dignified manner by the staff present during the meal service. Residents were provided with a choice of main meal and could also access alternative food should they not like what was on the menu. Inspectors observed the dining rooms to be well-laid out with table covers, menus, condiments and flowers set out on each table. There were three options of main meals provided each day, with roast beef, roast chicken and a salmon dish provided on one of the inspection days. There was a selection of snacks and refreshments available for residents throughout the day.

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

Capacity and capability

This inspection found that the designated centre was well-managed for the benefit of the residents who lived there. For the most part, the oversight and governance systems that were in place helped to ensure that care and services were provided in line with the designated centre's statement of purpose and, that residents were able

to enjoy a good quality of life in which their preferences for care and support were upheld.

There were however some areas that required improvement, these areas are described in more detail under the relevant regulations relating to governance and management, care planning, notifications of incidents, premises, fire and medicines and pharmaceutical services.

This was an unannounced inspection carried out over two days to review compliance with the regulations and to follow up on the improvement actions the registered provider had agreed to implement, arising from the inspection carried out in February 2024.

The Health Service Executive (HSE) is the registered provider for this designated centre. There is a clearly defined management structure in place that is accountable for the delivery of safe and effective health and social care support to residents. The management team consists of a general manager, a manager for older person services, a person in charge and an assistant director of nursing. A team of nurses, health care assistants, household, catering, maintenance, physiotherapy and occupational therapy support were also involved in the delivery of care to the residents in the designated centre.

Prior to this inspection, the registered provider submitted an application to vary conditions 1 and 3 of the registration, to address changes to the layout of the centre, resulting from a redevelopment programme, to provide additional bed spaces and to modernize the designated centre. However, inspectors also found that one additional change had not been notified to the Chief Inspector. This change re-purposed a store room on the unit to a staff area and had been completed at the time of the inspection. As the change had not been notified to the Chief Inspector, as required under the regulations, the provider was found to be in breach of Condition 1 of their conditions of registration.

There were regular provider and local team meetings to review the quality of the service provided. The agenda was broad and covered key areas of the service such as risk and clinical indicators.

A review of the designated centre's annual review of quality and safety for 2024 confirmed that residents and their families were consulted about the quality of services provided. As a result of this consultation improvement plans were identified for 2025 to maintain and improve upon the quality of services provided.

Records were well maintained and stored securely to maintain residents privacy and confidentiality. While, the majority of notifications were submitted in accordance with the regulations, two notifications where residents had attended an acute centre for review were not submitted in line with Schedule 4 of the regulations.

The provider implemented a systematic approach to monitoring the quality and safety of the service provided to residents. This included, a schedule of clinical, environmental and operational audits. Where improvements were identified, action plans were developed and actioned within defined time lines. However, the current

system to monitor and evaluate the effectiveness of care planning was not robust and was not identifying areas of practice that required improvement.

The registered provider maintained sufficient staffing levels and an appropriate skill mix across all departments to meet the assessed needs of the residents. 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.

There was effective oversight of the staffing resource to ensure a consistent service was provided. In instances where gaps appeared on the roster they were filled by existing team members which helped to ensure continuity of care for the residents.However, management confirmed that agency cover could be sought if needed.

The provider maintained a policy and procedure on complaints. Records confirmed that the provider investigated complaints in line with this policy. There were no open complaints identified on this inspection.

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill mix to meet the assessed needs of the residents in the designated centre. A review of the rosters confirmed that staff numbers were consistent with those set out in the centre's statement of purpose.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents in the designated centre was maintained by the registered provider and was made available for inspectors to review. The directory of residents detailed all the information regarding each resident as required by the regulations.

The directory of residents was up-to-date and included all of the resident information required under Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider was in breach of Condition 1 of their registration as they had changed the use and function of a store room identified on their floor plans and in the statement of purpose against which the centre was registered.

An application to vary Condition 1 of the designated centre's registration had not been submitted to the Chief Inspector prior to this inspection as required under Regulation 7 (2)(d) of the Registration Regulations.

The inspectors found that the registered provider had management systems in place to monitor the quality of the service provided, however some of these monitoring systems, such as audits were not fully effective in identifying areas of the service that required strengthening. This resulted in action plans not been developed to address these deficits and improve the quality and consistency of the services provided. For example:

- Audits were not identifying areas of practice that required improvement in relation to care planning, compliance with medicine protocols.
- The requirement to submit all notifications that met the three day threshold to the Chief Inspector had not been met.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the incident and accident reports found that not all notifications were submitted to the the Chief Inspector in accordance with the requirements of Schedule 4. For example:

- Two residents who required hospital treatment had not been notified to the Chief Inspector within the required notification period.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and this was updated in line with regulatory requirements. Records of complaints were maintained in the centre and the inspectors observed that these were acknowledged and investigated promptly and documented whether or not the complainant was satisfied.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider prepared,maintained and regularly reviewed the centres written policies and procedures in line with Schedule 5 the regulations. These documents were readily available to staff.

Judgment: Compliant

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider failed to submit an application to vary the condition 1 of their registration under section 52 of the Health Act 2007. As discussed under Regulation 23: Governance and Management , an alterations had been made to the function and use of a storage room in the designated centre by the registered provider,without submitting the required documentation on the proposed changes to the Chief Inspector prior to these changes been made.

Judgment: Not compliant

Quality and safety

Residents were supported and encouraged to have a good quality of life which was respectful of their choices. On the whole, there was evidence that residents were in receipt of positive health and social care outcomes and, that their assessed needs were being met. Regular consultation between the provider and residents ensured that residents' voices were being heard in this centre.

On the whole there was a high standard of assessment and care planning and regular care plan reviews which ensured that residents' assessed needs were met through suitable interventions. However, a review of assessment and care plan documentation found that these standards were not consistent. As a result some residents had an unmet need and were not afforded the opportunity to participate in the care planning process to address their care and support needs.

The inspectors found that residents had timely access to medical and, allied health care professionals. There were also arrangements in place for out of hours medical support for the residents. The registered provider ensured that there was a high standard of evidence based nursing care available in accordance with professional guidelines however, improvements were still reqiured in relation to the

administration of crushed medications in the centre. This was a repeat finding from the previous inspection and is addressed under Regulation: 6 Health care.

Staff and, resident interactions that were observed by the inspector and were found to be supportive and positive. This included discussions on what activities residents would like to be provided, the choice of food available for residents and on how residents would like care support to be provided to them. There were robust communication systems in place to ensure that residents were kept informed regarding key events in the centre. There was good use of notice boards to update residents on the availability of activities, access to advocacy and on how to register a complaint. In addition,resident meeting records confirmed that residents were communicated with on a regular basis.

The premises were on the whole well maintained, communal facilities were spacious and comfortable for residents to enjoy. Equipment including mobility equipment, hoists and hoist slings and residents' profiling beds were serviced regularly. Residents' bedrooms were suitable for the assessed needs of the residents accommodated in them. The layout of multi-occupancy bedrooms was well-managed to ensure that residents had easy access to their personal storage, and were able to sit out in a comfortable chair without impacting on the personal space of the other residents sharing these bedrooms.

There was unrestricted access to all areas of the centre including the internal courtyard gardens. Residents were observed accessing all areas of the home during the inspection.

The activity programme was advertised in all units On the day of the inspection the activity co-ordinator was observed planning an arts and crafts session with residents while later in the day a well attended music session was thoroughly enjoyed by all the residents present.

The inspectors observed good fire safety systems were in place. Service records were available for the various fire safety and building services and these were all up to date. The inspectors spoke with various staff members on duty in regard to fire safety and evacuation procedures. Fire safety training for all staff was up-to-date. Staff were confident and knowledgeable with the practiced evacuation procedures.

The inspectors reviewed the fire safety register and noted that it was well organised and comprehensive. The in-house periodic fire safety checks were being completed and logged in the register as required.

Notwithstanding this, a number of actions were required in relation to fire doors, fire precautions, fire sealing of service penetrations, evacuation procedures and storage practices, to ensure compliance. These are outlined in detail under Regulation 28: Fire Precautions.

Regulation 10: Communication difficulties

The inspectors observed that those residents with assessed communication needs were supported to communicate effectively in this centre. A range of communication aids were available to assist residents communicate, including electronic translators, computers, and picture tools. In addition, where a resident required specialist communication interventions needs, such interventions were recorded in the resident's care plans and implemented by staff.

Observations on inspection demonstrated that staff had good insight into residents' communication needs and supported residents to be independent.

Judgment: Compliant

Regulation 13: End of life

The inspector reviewed a sample of residents' care records and found that where the resident had expressed a preference for their end of life care that these wishes were recorded and were made known to staff. This included where the resident wished to be cared for. Where a resident preferred to go home or transfer to hospital this was recorded and their wishes were facilitated.

End of life care plans detailed the residents preferences for spiritual and family support at end of life. The resident's family and friends were encouraged and supported o be involved in the resident's end of life care and were made welcome in the centre.

The nursing and care team worked with specialist practitioners such as the palliative care team and the resident's general practitioner (GP) to ensure that appropriate care and comfort were provided for the resident.

Judgment: Compliant

Regulation 17: Premises

The centre was found to be clean, clutter free and overall maintained to a good standard.

Notwithstanding this, the registered provider having regard to the needs of the residents had mostly provided premises which conformed to the matters set out in Schedule 6. However, the following areas were identified on this inspection that required improvements:

- Stains were noted to high level windows in a sitting room in Our Lady's Unit.

- Maintenance was required to some fire doors and some areas had unsightly breaks in walls and ceilings around services that required repair and redecoration to improve appearance and to ensure adequate containment of fire.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy which met the requirements of the regulations. Notwithstanding the management of fire safety risks in the centre as set out under Regulation 28 in this report other risks were found to be well-managed.

In instances where hazards were identified, appropriate controls were put in place to either remove or reduce the identified risk. A review of incidents and accidents was carried out by the provider in an attempt to identify learning opportunities to improve the service to the residents.

Judgment: Compliant

Regulation 27: Infection control

The registered provider ensured that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff. Up-to-date training had been provided to all staff in infection control, hand hygiene and in donning and doffing of personal protective equipment (PPE). A schedule of resident and staff meetings were maintained and changes to guidance from public health and the Health Service Executive (HSE) were discussed to ensure that all were familiar with the up-to-date guidance.

Regular infection prevention and control, environment and hand hygiene audits, found good levels of compliance. The inspector also noted that staff were seen to perform hand hygiene and, wear PPE at appropriate times while caring for residents.

Effective cleaning processes were in place to support and, maintain high levels of cleanliness.

Judgment: Compliant

Regulation 28: Fire precautions

The oversight of fire safety in the centre had improved since the previous inspections of the centre and provider was working towards bringing the centre into compliance. Notwithstanding this, the registered provider was required to carry out improvements in the following areas:

Day-to-day arrangements in place in the centre to provide adequate precautions against the risk of fire required improvements. For example:

- The inspectors observed a room used to house a large electrical terminal, along a corridor, was being used as a storage area. The inspectors observed the inappropriate storage of a cardboard box in this area. This presented a potential fire risk-if a fire did develop, it would be accelerated by the presence of this item. This was brought to the attention of staff and was immediately removed by staff.

The provider needed to improve the maintenance of the building fabric. There were adjustments and maintenance required to some fire doors and some wall areas to ensure adequate containment of fire and smoke in the event of a fire emergency. For example in Our Lady's Unit;

- A magnetic hold open device was loose and needed securing.
- Sets of double fire doors into some of the multiple occupancy-bedrooms were found with; smoke seals partially damaged, not fully secured in place and gaps over the allowable tolerances were found between door meeting stiles.
- A set of double doors into a sitting room and a large store room were noted to have gaps between the door meeting stiles and, some signs of damage to the door and the smoke seals..
- A fire door into a clinical room failed to close fully when tested by the inspector.

In St Michael's Unit;

- A fire door into a storage room was found to not be fitted with a self-closer
- A set of cross corridor fire doors did not fully align when in the closed position.

In St Catherine’s Unit;

- A fire door into a sensory room was missing a self-closer.
- Furthermore, along the main link corridor, a fire door into an electrical terminal room was missing a self-closer. This impacted the ability for the containment of fire in these areas.

The inspector noted some areas in the centre were observed to have utility pipes or ducting that penetrated through the fire-rated walls (walls built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures. This was evident; above a set of cross-corridor doors at the main entrance area and a large hole was noted around a cable trunking through a wall.

Arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency in the centre required improvement by the provider. For example:

Regular fire evacuation drills were taking place based on day and night time staffing levels. From a review of drills for the largest compartment indicated an extended evacuation time. This implied a deficit in the evacuation strategy. Furthermore, repeated observations and learning were outlined in a series of drills in regards to issues; with a door not opening, a lack of roll calls, obstructions and delays in the evacuation. As such, improvements to the evacuation strategy and the implementation of the drill observations were required in order to evacuate all residents from the largest compartment in a safe and timely manner.

In addition to this, the inspector noted not all fire evacuation routes were being regularly tested to ensure staff rostered at night time were adequately familiar with all available routes, in particular from St Michael's and Our Lady's units.

The displayed procedures to be followed in the event of a fire required a review by the provider. For example,

Fire evacuation floor plans were on display throughout the centre and indicated evacuation routes and the perceived compartment boundaries. However, the inspectors noted the floor plans were not accurate as 60 minute fire compartments had been indicated where only 30 minute fire rating compartments existed. These floor plans would form part of the progressive horizontal evacuation for staff in the event they were required to evacuate residents from the source of the fire and into the adjoining 60 minute fire rated compartment boundary.

The floor plans were required to be updated to reduce the risk of residents to only being evacuated into an adjoining sub compartment boundary, instead of ultimately being evacuated into a 60 minute fire compartment boundary that affords sufficient protection from fire and smoke.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were comprehensive policies and procedures in place for the administration of medicines, however the provider failed to ensure that all medicines were administered in accordance with the prescriber's instructions. For example:

- Crushed medications for a resident had not been signed by the resident's general practitioner (GP). This was a recurrent finding from the previous inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of care records and found that although residents had a comprehensive assessment of their needs,there were some care plans that did not address all assessed needs, for example:

- One resident did not have a care plan in place that clearly set out how their medical condition was to be managed.
- One resident's care plans was not formally reviewed within four months of their development.
- One resident did not have a careplan developed within 48hrs based on their assessed need.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that the provider had taken all reasonable measures to protect residents from abuse. Staff who were met in the course of the inspection confirmed that they had attended safeguarding training and were confident that they would be able to use this training to ensure that residents were protected from abuse.

A review of records relating to one safeguarding incident found that the registered provider ensured that this incident was investigated promptly in line with their safeguarding policy, and that appropriate measures were identified and implemented to protect the residents concerned.

Judgment: Compliant

Regulation 9: Residents' rights

There were arrangements in place for residents to pursue their interests on an individual basis or to participate in group activities in accordance with their interests and capacities. There was a schedule of activities in place which was available for residents to attend seven days a week. Residents also had good access to a range of media which included newspapers, television and radios.

Resident meetings were held on a regular basis and meeting records confirmed that there was on-going consultation between the staff and residents regarding the quality of the service provided.
Judgment: 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 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sacred Heart Hospital & Care Home OSV-0000654

Inspection ID: MON-0044697

Date of inspection: 07/02/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The temporary room partition wall has since been removed The Care Plan and Medicines Management audit tool were reviewed and updated to include the Inspectors recommendations. Audits are complete by the Clinical Nurse Manager on a 4 monthly basis whom completes an action plan based on the findings. The National Nursing & Midwifery Quality Care Metrics (QCM) MEG platform (previously known as Test Your Care) also remains operational in the facility to support, promote and identify improvements to care. The Director of Nursing and Assistant Director of Nursing review the action and quality improvement plans at the Nurse Management Team Meetings. Management will submit the required notifications in keeping with documented regulatory requirements.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Management will submit a notification to HIQA if a resident is admitted to an acute hospital following any serious incident or injury as per the Health Act 2007 Amendment SI No 1 of 2025, operational since 31st March 2025.	

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: The temporary room partition wall has since been removed and functions as a Store Room as per floor plans and statement of purpose	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A specialist Fire Safety & Protection company have complete all adjustments and maintenance required to the fire doors and wall areas identified in the report. Regular Fire Evacuation Drills are held in all areas focusing on strategy, competence and learning. The observations identified from each fire drill completed are discussed with the staff and reviewed. The fire evacuation drill that was completed in the largest compartment prior to the inspection consisted of an evacuation of 18 residents within 5 minutes 4 seconds. On the same ward an evacuation of 28 Residents was completed in 10 minutes and 11 seconds. A schedule of training is in place to support the process. Fire Evacuation Floor Plans updated and displayed. The new electrical room on the corridor, which relates to the new build extension, is now locked and accessible only to authorized personnel. The non-compliance identified on inspection in relation to this room was addressed on the day and evidenced to the Inspector.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The Residents prescription kardex front cover did have a 'Special Consideration' instruction that medications were to be crushed, however the General Practitioner (GP)	

did, on the day of the inspection, add the word crush to each individual tablet prescription and is the practice since.

A working group met on the 13th February to review and redraft the existing medicines prescription kardex to include a designated box at each drug prescription for the GP to indicate if the medicines are to be crushed.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The Resident care plan was updated on the day of inspection to include a managed medical condition.

The Resident care plan requiring review was carried out and staff reminded at daily handover and staff meetings to ensure that same is complete within the 4 months date.

Staff reminded that a Resident care plan must be developed within 48hrs and to delegate this requirement to a colleague as appropriate to ensure compliance.

The Care Plan audit tool were reviewed and updated to include the Inspectors recommendations. Audits are complete by the Clinical Nurse Manager on a 4 monthly basis whom completes an action plan based on their findings. A final report is disseminated and discussed with staff at ward meetings.

The National Nursing & Midwifery Quality Care Metrics (QCM) MEG platform (previously known as Test Your Care) also remains operational in the facility to support, promote and identify improvements to care.

The Director of Nursing and Assistant Director of Nursing review the report with the associated action, recommendations and quality improvement plans at the Nurse Management Team Meetings.

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
Registration Regulation 7 (2)	An application under section 52 of the Act must specify the following: (a) the condition to which the application refers and whether the application is for the variation or the removal of the condition or conditions; (b) where the application is for the variation of a condition or conditions, the variation sought and the reason or reasons for the proposed variation; (c) where the application is for the removal of a condition or conditions, the reason or reasons for the proposed removal; (d) changes proposed	Not Compliant	Orange	21/03/2025

	in relation to the designated centre as a consequence of the variation or removal of a condition or conditions, including: (i) structural changes to the premises that are used as a designated centre; (ii) additional staff, facilities or equipment; and (iii) changes to the management of the centre that the registered provider believes are required to carry the proposed changes into effect.			
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	21/03/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	11/04/2025

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.	Not Compliant	Orange	11/04/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	11/04/2025
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	14/02/2025
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	07/02/2025

Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	07/02/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	14/02/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	14/02/2025