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:	Leopardstown Park Hospital
Name of provider:	Leopardstown Park Hospital
Address of centre:	Foxrock, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	22 January 2025
Centre ID:	OSV-0000667
Fieldwork ID:	MON-0044109

About the designated centre

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

Leopardstown Park Hospital provides care for adults who have long term needs for residential care. The centre provides services for residents with low dependency through to those residents who are maximum dependency and require full time nursing care, including care for residents who have dementia and for residents who need end of life care. Accommodation is provided across five units accommodating 120 male and female residents. Clevis unit has 29 beds and provides accommodation and services for residents who have low dependencies. The other four units provide accommodation and services for residents with higher levels of need and are located within the main hospital building. Glencullen and Glencree commonly known as the Glens units provide accommodation for 21 residents in Glencree and 22 residents in Glencullen, in a mix of single and multi-occupancy rooms. Orchard and Avoca units were recently renovated and both provides accommodation for 20 residents each. Djouce unit was also recently refurbished and accommodates 8 residents.There are garden areas to the front and rear of the property with seating available for residents. There is a large car park to the front of the building with some disabled parking spaces available. respectively.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	112

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
Wednesday 22 January 2025	09:00hrs to 17:20hrs	Aoife Byrne	Lead
Wednesday 22 January 2025	09:00hrs to 17:20hrs	Helen Lindsey	Support
Wednesday 22 January 2025	09:00hrs to 17:20hrs	Frank Barrett	Support

What residents told us and what inspectors observed

Inspectors found that Leopardstown Park Hospital was a well-run centre where residents were supported by a team of staff who were kind and caring. From what inspectors observed and from what residents told them, residents were happy with the care and support they received. Those residents who could not articulate for themselves appeared comfortable and content.The centre had a relaxed and friendly atmosphere. It was apparent residents enjoyed a good quality of life in the centre.

The centre is located in Foxrock, Dublin 18. The centre is registered for 120 residents with 8 vacancies on the day of the inspection. There are five units accommodating residents, Glencullen, Glencree, Orchard, Avoca and Djouce are all on the ground floor in the main building and Clevis unit is situated outside the main building and laid out over two floors. Residents were able to personalise their own rooms and many contained items personal to that individual. For example, inspectors saw residents' brought some furniture from home and others had plenty of plant pots.

Overall, the premises was found to be clean, warm and bright. Residents said their bedrooms were cleaned on a daily basis and they were satisfied with the standard of cleanliness The inspectors observed that the level of cleanliness throughout the centre was good. There was a series of well maintained garden areas, which residents were involved in the planting and maintenance. Inspectors spoke to a resident who had expressed his enthusiasm for gardening, and said that he was "glad to have a place to garden that people can enjoy". Internally, residents areas were separated into the various units. There were link corridors between most units except the Clevis unit which was in a separate building. Inspectors saw that resident areas were in a good state of repair, but that some ancillary areas, and the administration area required more maintenance attention.

Residents could attend the combined sitting and dining rooms in their units or have their meals in their bedroom if they preferred. Place settings were laid out for residents prior to their meals and residents appeared relaxed and comfortable in the dining spaces where they enjoyed conversation between fellow residents and staff during their meals. Staff were observed sitting beside residents assisting them with their lunch in an unrushed manner. Menus were displayed on a white board in the dining room.

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

Capacity and capability

This was a one day unannounced inspection undertaken to monitor ongoing compliance with the regulations. Overall there were good governance and management systems in place which ensured that that the service was appropriate to the needs of the residents.The registered provider ensured that sufficient resources were available to allow a high level of care to be provided to the residents. There was a well defined, overarching management structure in place. However some areas for improvement were identified as further described in the report.

Leopardstown Park Hospital is the registered provider for the designated centre. The person in charge was supported in their role by an assistant director of nursing, clinical nurse managers, a team of staff nurses health care assistants, housekeeping, catering, activities, laundry and administration staff.

This inspection included a review of fire safety practice and procedure at the centre, with particular attention on the Clevis unit, which is a unit in a building a short distance away from the main centre. Arrangements in place at the centre, to manage the risk of fire to residents were robust. There were audits completed on escape routes, fire alarm tests, and up to date service records available for the emergency lighting and fire detection and alarm systems. Nonetheless, evacuation aid drawings which show compartments, primary and secondary escape routes, assembly points etc were not displayed throughout the centre to assist with the evacuation process.

A fire safety risk assessment (FSRA) was completed in 2019, and was due for a review. All of the actions arising from that assessment had been completed. There was a clear policy in place relating to the management of residents smoking, however, inspectors noted that smoking was taking place in the Clevis unit in an external area that had not been designated as a smoking area. Furthermore, there was an internal smoking room in the Clevis unit that was open to the evacuation route. This had not been identified as a risk to the means of escape, on the audits completed, or on the FSRA. This meant that inspectors could not be assured that staff would be able to evacuate those residents safely and in a reasonable time in the case of a fire.These issues are discussed further under regulation 23 Governance and Management. Further fire safety issues are discussed under regulation 28: Fire Precautions.

There was evidence of regular meetings which informed the safe delivery of care such as clinical governance meetings, staff meetings and residents meetings. It was clear these meetings ensured effective communication across the service. The quality and safety of care was being monitored through a schedule of audits including audits on falls, care plans and infection prevention and control. Many audits had recorded high levels of compliance, however, these results did not align with some of the inspectors' findings. This is further discussed under Regulation 23: Governance and Management.

An annual review of the quality and safety of care delivered to residents had been completed for 2023 and management were in the process of completing the 2024 annual review.

There was a policy in place that set out the role of the complaints officer, and the complaints review officer. A flowchart was displayed in some areas of the centre setting out how to make a complaint, and a summary of the process. Where complaints had been made records reviewed by the inspector showed that the issue was reviewed, and any learning identified was recorded and acted on. However, further action was required with regard to informing the complainant the process for reviewing a compliant if they were not happy with the outcome, which is set out under regulation 34.

The inspector followed up on the actions identified by the provider outlined in the compliance plan following the last inspection in December 2023. The registered provider had taken action to ensure compliance with the regulations and improvements were observed by the inspector in areas such as Regulation 16: Training and staff development and Regulation 27: Infection prevention and control.

Regulation 16: Training and staff development

Staff had access to a programme of training that was appropriate to the service. Staff training records confirmed that all staff were up-to-date with mandatory training such as fire safety, safeguarding and infection prevention and control.

Judgment: Compliant

Regulation 19: Directory of residents

There was a directory of residents available in the designated centre. However, from the sample reviewed not all the information as required in the regulations was available. For example;

- The next of kin's name and contact details were not available for seven residents
- The contact details for medical officer was not completed for seven residents

Judgment: Substantially compliant

Regulation 22: Insurance

A contract of insurance was available for review. The certificate included cover for public indemnity against injury to residents and other risks including loss and damage of residents' property.

Judgment: Compliant

Regulation 23: Governance and management

While the centre had a wide range of assurance systems in place, further oversight was required in order for the registered provider to be assured of the quality and safety of care in all areas:

- Care Plan audits were completed, however there was no evidence that the quality improvement plan had been implemented. While these audits had recorded high levels of compliance, this was not in line with inspectors' findings, for example in respect to nutrition care plans. This is further discussed under Regulation 5: Individual assessment and care plan.
- Further oversight is required to ensure care plans are person centred for example: Inspectors observed a lack of detail in a sample of end of life and sleep care plans. These contained generic templates and were not person centred.
- Tracking and trending of falls was taking place but no evidence was seen of the actions to address the trends identified.
- The registered provider did not ensure that systems were in place to ensure the service provided was safe with particular regard to the oversight of fire safety and ensure adequate precautions against the risk of fire for example: fire evacuation plans were not in place on walls within the centre to show the information to assist evacuation in line with the policy at the centre. This is further discussed under Regulation 28: Fire Precautions.
- There was poor oversight of the implementation of the centres smoking policy in the Clevis unit. An external area used for smoking was not clearly identified as a designated smoking area in line with the policy, and did not have the required fire fighting equipment, or the fire safety precautions in place to protect residents that smoke.
- Fire safety audits including means of escape audits and fire safety risk assessments had not identified the risk imposed by smoking within the conservatory in the Clevis unit. This conservatory formed part of an escape route from the dining area, and thereby evacuees using this route, would have to exit through the smoking area. The practice of smoking within this space introduced a risk of fire to this escape route.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Contracts of care were seen to be in place for residents. They included the fee a resident was to pay, and any additional costs for services not included in the fee. Also, how many occupants there were in that room i.e. twin or single room.

Judgment: Compliant

Regulation 34: Complaints procedure

While there was a clear procedure in place to manage complaints, it was noted that the letters sent to the complainant to inform them of the outcome of the complaint, did not include 'details of the review processes as required by the providers policy, and the regulation.

Judgment: Substantially compliant

Quality and safety

Overall residents were seen to be receiving a good standard of care and support from a staff team who knew them well. There had been an investment programme in relation to the premises, and now no more than four people were sharing a bedroom, and each person had a bed space with sufficient storage. Residents in shared rooms were able to undertake activities in private, with bed curtains that went fully around the bed space. While the provider had addressed a number of issues from the last inspection, a small number were outstanding, for example not all residents had access to lockable storage.

Inspectors reviewed the premises of Leopardstown Park Hospital during this inspection. A large campus such as this requires significant resources to maintain the centre both internally and externally. While there were areas that required improvements, the centre was well presented. There were Individual garden areas that residents were encouraged to assist in maintaining to their own liking. It was clear that some residents enjoyed this activity, and this had improved the overall environment of the centre. There were some signs of wear and tear issues that required action including evidence of dampness in a laundry area. Carpets on the

floor of the Clevis unit were also in need of repair/replacement as they were frayed and some were taped down on the joints, and could be a trip hazard. Storage issues persisted at the centre with inappropriate storage of materials in overfilled storage spaces, and flammable and combustible items being stored in close proximity to each other. The use of the conservatory B within the clevis unit as a smoking area required review, as it had been allocated as a communal place for all residents, which was not practical as it was set up as a smoking room. These and other premises issues are discussed under regulation 17: Premises.

The measures in place to protect residents from the risk of fire were reviewed on this inspection. The Clevis unit was reviewed in detail, and systems in place in that unit reflected good practice overall in protecting residents from the risk of fire. The Clevis unit is laid out over two floors, and while there had been significant upgrades to fire safety, some issues remained. There was a central escape stairs within this unit, and alternative escape from the first floor was facilitated through the use of external escape stairs at the end of the corridors. Staff indicated that they had not practiced evacuation of any residents using the external stairs, however, overall, staff were very knowledgeable on fire safety procedures. The risk fire during smoking required improved oversight, as the external smoking area was not provided with appropriate fire prevention measures, fire extinguishers, or means of calling for assistance in the case of difficulty while smoking. Fire containment measures were also assessed within the Clevis unit. Upgrades to fire doors and containment measures had been completed in line with the FSRA completed in 2019, however, one resident living on the first floor of the clevis unit did not have appropriate fire containment measures available to them, as the compartment door was not effective at the top of the stairs. There was also a concern raised with the layout of the laundry area, as the exit route through the staff area at the rear of the laundry did not have appropriate separation from the laundry area, which is a place of higher fire risk. These and other fire safety issues identified are detailed further under regulation 28: Fire Precautions.

A number of care plans reviewed by inspectors were person centred and reflected the preferences and choices of residents. Some good examples were seen relating to setting out a residents needs in relation to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and clear guidance of a resident's diabetes, including what to do if their blood levels were altered. However there were examples seen that did not have sufficient information to guide staff practice. For example one care plan said a resident had medium risk of falls, and the next line said they had a high risk of falls. Another example said a resident didn't have any pressure wounds, however there was a separate care plan for a pressure wound.

Where residents were able, they were spending their time as they chose. Some residents chose to spend their time mostly in their bedrooms, and they were able to do this. Other residents were seen to be in bedrooms during the morning, either sleeping, watching television, or involved in other activities of their choice such as reading and then in the communal areas after lunch. Staff confirmed that the

morning routine was led by the resident's preferences regarding when to get up, where to have breakfast, and how to spend their time.

Some residents were in single rooms. Where there were more than one person in a bedroom, inspectors saw curtains were pulled around bed spaces for privacy in the morning. In the afternoon, it was noted some rooms had all the privacy curtains open, others had them closed, as per their own preferences.

There was access to a TV for each resident, with earphones, to ensure the sound didn't affect others in shared bedrooms. There was access to music, musical instruments and wifi through the centre.

While residents were choosing their own morning routine, it was noted that only two units had access to organised activities to offer interest, and engage the residents. On the day of inspection there was a bingo session in the concert hall attended by approximately 20 residents, and a guitar sing along in one other unit, however the other units had no activities. This meant for many residents, there were no activities provided in the morning or afternoon on the day of inspection.

Regulation 17: Premises

While significant improvements had been made to the premises, some further improvements were required to ensure full compliance with regulation 17 and to ensure the service is operated in line with Regulation 3: the statement of purpose. For example;

- The conservatory B area within the Clevis unit was registered as a communal space for all residents. On the day of inspection, this room was used as a smoking area, and was not available for all residents to use.

Improvements were required by the registered provider to ensure that, having regard to the needs of the residents at the centre, all items set out in Schedule 6 of the regulations were in place. For example:

- Suitable storage space was presenting an ongoing issue, for example:
    - Storage space within the laundry area of the Clevis unit was overfilled, and various types of items were stored together such as clinical items including nebulisers and dressings, with hand gels, personal items such as aerosols, and plastic gowns.
    - The clean utility in Glencullen and Glencree was both a clinical and administrative room. Medication and dressings were stored in the room where files were kept. This room did not contain a hand hygiene sink.
- Not all residents had access to lockable storage
- Some areas of flooring required repair/replacement. For example:

- Floor covering in the visitors room in Glencree was in a state of disrepair.
- Carpets on the floor of the Clevis unit were frayed along some of the edges, were heavily worn on other parts, and some of the joints were taped using black plastic tape. This was particularly noticeable on the first floor landing, where the sticking tape was peeling off presenting a trip risk to anyone moving down the stairs.

- The wall in the Clevis Unit laundry was showing signs of dampness which was impacting on the integrity of the surface of the wall. This was in the clean section of the laundry where residents clothes were being ironed. There was paint flaking and plaster damage on the wall. This would mean the wall could not be effectively cleaned.
- Paint was peeling off the ceiling in a dining room in the Clevis unit. This appeared to be as a result of a previous leak.
- Areas of the administration building were in need of maintenance attention, with ceilings walls, and some doors damaged with holes in a section of wall on the second floor corridor.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was a menu for the day available in each of the units in the centre. The menu showed two choices for each meal, and staff said the chef would facilitate requests if residents preferred another option.

Drinks and snacks were provided at intervals through the day, and there were a selection of drinks available in the kitchenettes, for residents to access. There were also water fountains that could be accessed at all times.

Many residents were seen to have their lunch in the main dining rooms, which overall provided a pleasant environment. Where residents required support with eating, this was offered discreetly by staff. Resident's independence was supported with a range of equipment, including specialised cups and cutlery.

Judgment: Compliant

Regulation 20: Information for residents

There was a booklet for residents setting out key information about the service, including how to make a complaint, a summary of the services provided, and the arrangements for visiting the centre.

Judgment: Compliant

Regulation 26: Risk management

While the policy set out how to identify hazards, and the measures and actions to control risks, it did not include the specific areas named in the policy. For example, accidental injury to residents, visitors or staff, and self-harm.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was clean throughout, and cleaning staff spoken with were clear about the cleaning procedures in place. Records showed there was a comprehensive plan for cleaning all areas of the centre, and the list of completed tasks was checked and signed off by a manager.

Following up on the compliance plan from the last inspection, all actions were taken to meet the requirements of the regulations.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, while improvements had been made to address fire safety concern, this inspection found that further action was required to protect residents from the risk of fire.

For example:

- Smoking practice at the centre was increasing the risk of fire to residents. The external smoking area in the Clevis unit did not have appropriate fire safety measures in place. There was no fire extinguisher (this was placed at the area before the end of the inspection), there was no call bell facilities to allow residents to call for help, there was no appropriate fire retardant furniture or ash tray to manage the risk of fire in this area. In the Glencree smoking area, there was also no call bell available and no fire extinguisher.
- Storage practice was presenting a risk of fire to residents at the centre. Flammable and combustible items were inappropriately stored in the laundry room of the Clevis unit.

A review of the means of escape and emergency lighting was required by the registered provider for example::

- There was no appropriate emergency lighting in place at the fire exit from the conservatory B area in the Clevis unit. This would result in difficulty to evacuation through this route in the event of a fire and power loss.
- External pathways from the fire exit to the side of the Clevis unit did not link up to provide a usable route to the assembly point. Some of the pathways ended at a grassed area. This would present difficulties to residents with mobility difficulties during evacuation to the assembly point in the event of a fire.
- One of the exit routes from the dining room in the Clevis unit required evacuees to travel through the internal smoking area. This meant that the smoking area was located within the escape route. This presented a risk to the escape route in the event of a fire, as route was not a protected escape providing relative safety during evacuation

Improvement was required by the registered provider to make adequate arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout, and escape routes, location of fire alarm call points, first aid fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire. For example:

- While fire drills were taking place at the centre, and staff were aware of the procedures to follow in the event of a fire, staff had not trained in the use of the external escape stairs as an evacuation route within the Clevis unit. These external stairs were providing secondary escape means at the ends of all the corridors.
- There were no layout drawings to illustrate the evacuation direction, the location of fire alarm call points, compartment lines etc. as required by the regulations

Improvement was required by the registered provider to make adequate arrangements for containing fires. For example:

- A door fitted in the landing at the top of the stair of the Clevis unit, did not appear to be a fire rated compartment door. The door was not fitted with appropriate hinges or glazing and did not have the characteristics of a fire rated compartment door.There was one resident bedroom which opened into this section of corridor. This meant that inspectors could not be assured that this bedroom was suitably protected through compartmentation from the landing area, and subsequently, the ground floor area. This would impact on the progressive horizontal evacuation of this resident in the event of a fire**.**
- The escape route on the ground floor of the Clevis unit through the staff break area, was not separated with appropriate fire rated construction, from the laundry area, or the phone booth room. This could lead to reduced options to escape in the event of an evacuation as the escape route and the laundry area were effectively in the same compartment, and the escape route

would not be a protected escape route. This route was an alternative escape from the dining area and from the corridor linking the dining to the front of the building.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While there were care plans in place for residents identified needs, improvement were required to ensure they were up to date, and effectively guide staff in the provision of care to residents. For example;

- While there was evidence that the dates on the care plans review were updated on a four monthly basis. Two residents care plans still included information from March 2023 which was outdated.
- A newly updated comprehensive assessment and care plan were not in agreement in relation to nutritional status of a resident.
- Two comprehensive assessments for newly admitted residents were not completed within 48hours of the residents admission. These comprehensive assessments were not fully completed.
- A care plan said a resident wasn't able to weight bare, and required a wheelchair, however they were seen mobilising around the centre with a walking frame.

Judgment: Substantially compliant

Regulation 6: Health care

There was access to a GP five days a week, and on-call arrangement for evenings and weekends. Records showed residents were assessed by a GP on admission, and reviewed on a regular basis, more frequently where required.

There was access to a range of healthcare professionals on site, including occupational therapist, dietician, speech and language therapy and physiotherapist. Assessments seen on file for residents showed they were assessed quickly where referrals were made, and there were clear plans put in place to address the identified issue, for example if a residents ability to chew food had changed, or if a resident was at high risk of falls.

There was also access to other medical professionals, including psychiatry of old age and geriatrician to ensure needs were being met.

Judgment: Compliant

Regulation 9: Residents' rights

The number of activities co-ordinators working in the centre was the whole time equivalent of 1.5, which was below the number of three that should be in post, as stated in the statement of purpose. The impact of this was seen, with a limited activities timetable available, across the 6 units in the main building, resulting in long periods of time where residents had no access to social activities.

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 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Leopardstown Park Hospital OSV-0000667

Inspection ID: MON-0044109

Date of inspection: 22/01/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: • Completed missing contact details for Nominated representative (next of kin) and GPs on 27/01/2025. • Implemented a routine review process led by CNM3, commenced 27/01/2025, to ensure ongoing accuracy. • To continue quarterly audits, with the next review scheduled for 30/04/2025.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Conduct weekly Falls-Specific IDT meetings with multidisciplinary teams to analyse individual falls. • Utilize a multifactorial falls risk assessment, considering harm sustained, medication, mobility, and environmental factors. • Review quarterly Falls and Level of Harm incident reports at Falls Committee meetings, with the next meeting scheduled for 10/04/2025. • Verified that all fire evacuation plans are displayed on walls within the centre to assist with evacuations, in alignment with the centre's fire safety policy. • Requested evacuation map from contactors for Clevis and is expected to be received by March 31st. • Clearly mark the external smoking area with posters by 28/03/2025. • Ensure required firefighting equipment (two fire extinguishers and one fire blanket) is installed by 30/03/2025.	

• Conduct a fire safety compliance audit by 31/03/2025.

• The identified fire safety risk has been mitigated by permanently closing the existing smoking room, which was located at the rear of the dining room and formed part of the escape route. A new designated external smoking area has been established to ensure compliance with fire safety regulations.
• Fire safety standards will be upheld by removing smoking from escape routes and monitoring adherence through ongoing risk assessments.
• The cement groundwork for the new smoking area has already been completed, and the structure has been ordered, with an expected delivery date of 15th April.
• This action aligns with HIQA standards, fire safety best practices, and the hospital's commitment to resident safety by ensuring that all designated escape routes remain unobstructed, and fire hazards are minimized.
• The transition plan includes:
• Physical completion of the new smoking area by mid-April.
• Ongoing communication with residents to ensure cooperation and compliance.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The amended complaints procedure, implemented on 12th February, explicitly incorporates the 30-working-day resolution timeframe, ensuring transparency, accountability, and compliance.
• Compliance with the 30-day resolution timeframe will be systematically reviewed and verified to ensure all complaints are addressed within the required period.
• The updated procedure has been communicated to all relevant staff to ensure adherence.
• Monitoring mechanisms are in place to track complaint resolution timelines and identify any delays.
• Ensuring timely complaint resolution aligns with HIQA standards, resident satisfaction, and hospital governance best practices, reinforcing a transparent and effective complaints process.
Time-bound:
• A compliance review will be conducted by 31st March 2025 to assess adherence to the 30-day resolution timeframe.
• Any necessary adjustments or improvements will be implemented following the review.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: • Close the conservatory B smoking room by 28/04/2025 and relocate it to a designated external smoking area. • Complete the designated external smoking area by 25/04/2025 to eliminate any risk and ensure compliance. • Conduct a compliance review by 30/04/2025 to verify adherence to HIQA regulation 17. • Completed the reorganization of the laundry area on 21/01/2025. • Ensure that clinical items (e.g., nebulisers, dressings) and personal items (e.g., aerosols, hand gels) are stored in designated, lockable storage spaces. • Verify lockable storage access and compliance by 22/01/2025. • Completed the reorganization of the laundry area on 21/01/2025. • Ensure that clinical items (e.g., nebulisers, dressings) and personal items (e.g., aerosols, hand gels) are stored in designated, lockable storage spaces. • Verify lockable storage access and compliance by 22/01/2025.	
Regulation 26: Risk management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management: • Revise risk management policy to explicitly include accidental injury and self-harm by 30/04/2025. • Begin the review process on 31/03/2025. • Conduct a compliance evaluation by 31/05/2025.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: There is no designated external smoking area for Clevis. • To ensure full compliance, the ground-floor escape route through the staff break area will be properly separated from the laundry area and phone booth room using certified fire-rated construction materials. • The compartmentation of the laundry, kitchen, and staff dining room will be reassessed to verify adherence to fire safety standards and regulatory requirements. • Contractors have been engaged to review the existing fire safety measures, assess necessary improvements, and implement required modifications.	

• This action aligns with fire safety best practices, regulatory compliance, and risk mitigation strategies, ensuring that all alternative escape routes remain protected and functional.
• Time-bound:
o Contractors will conduct an immediate review of the escape route structure to confirm whether additional fireproofing is required.
o Remedial works, if required, will be scheduled promptly to ensure fire-rated compartmentation is achieved.
o Existing documentation and floor plans from the 2020 system upgrade will guide the necessary adjustments.
Supporting Information
During the 2020 fire safety system upgrade, remedial works were completed on walls and windows to fireproof the area. The laundry, kitchen, and staff dining room are currently within the same compartment, as reflected in the attached floor plan. Contractors will verify whether further improvements are necessary to enhance fire safety compliance.
To ensure a safe and accessible escape route, a new external pathway has been constructed from the fire escape door on Sycamore Drive and Beech Avenue, ensuring a direct and unobstructed route to the assembly point.

The new pathway provides a continuous and level surface for safe evacuation, eliminating previous mobility barriers.
• The construction of the pathway was completed following the fire safety inspection, ensuring full accessibility and compliance with evacuation protocols.
• This improvement aligns with fire safety best practices, HIQA regulations, and the hospital's commitment to ensuring safe evacuation for all residents, including those with mobility impairments.
• Time-bound:
• The pathway construction has been fully completed following the inspection.
• Ongoing monitoring and maintenance will be conducted to ensure its usability remains optimal over time.

• The internal smoking area within the escape route has been permanently closed, and a designated external smoking area has been established, eliminating fire risks within the escape route.
• This change ensures full compliance with fire safety regulations by removing smoking-related fire hazards from all designated evacuation paths.
• Closure of the internal smoking room has been implemented.
• Cement groundwork for the new external smoking area has been completed, and the structure is on order, with delivery expected by 15th April.
• This measure aligns with fire safety best practices, HIQA regulations, and risk mitigation strategies, ensuring that all escape routes remain protected and free from potential ignition sources.

Time-bound:
• Internal smoking area closed immediately following identification of the risk.
• External smoking area expected to be fully operational by 30/04/2025.
• Ongoing monitoring to ensure compliance and safety post-transition.

• The non-compliant door on the landing will be replaced with a certified fire-rated compartment door, ensuring appropriate hinges, fire-resistant glazing, and compliance with fire safety regulations.
• The new fire-rated door will meet all regulatory fire resistance and compartmentation standards, providing assured protection for the resident's bedroom and adjacent areas.
• Maintenance /Master Fire has been engaged to assess and install the required fire-rated door.
• The installation will ensure proper compartmentation between the resident's bedroom, the landing area, and the ground floor.
This action is critical to ensuring compliance with HIQA fire safety regulations, progressive horizontal evacuation protocols, and the hospital's commitment to resident safety.
Time-bound:
• Immediate engagement with Master Fire to confirm specifications and installation timeline.
• Installation to be scheduled and completed as a priority.
• Post-installation assessment to verify compliance and effectiveness.

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 plans and assessments were last reviewed and updated on 22nd January 2025, ensuring compliance with HIQA's four-month review requirement.
• Regular audits and staff discussions are in place to monitor and improve care planning, using monthly metrics audits and four-monthly person-centred care plan audits.
• The next four-monthly clinical documentation audit is scheduled for 17th March 2025 and will be conducted by Enhanced Nurses.
• Monthly metrics audit reports will be generated at the end of every month to track compliance and quality of care planning.
• These measures align with best practices in person-centred care, ensuring that care plans remain up-to-date, relevant, and responsive to residents' changing needs.

Time-bound:
• Four-monthly clinical documentation audit will continue as scheduled, ensuring compliance with HIQA's required review intervals.
• Monthly metrics audits and reporting will be conducted at the end of each month.
• Action plans for both metrics and clinical documentation audits will be discussed with CNMs, who will formulate and implement necessary improvements accordingly.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Unit-level activity facilitators have been organized as of 10th February 2025, ensuring structured and tailored activity programs for residents.
• Activity programs will be reviewed and updated on a monthly basis, ensuring they reflect residents' evolving interests and capacities.
• Activity facilitators will engage with residents regularly to assess participation and preferences.
• Feedback mechanisms will be in place to track resident satisfaction and engagement levels.
• Providing meaningful and person-centred activities aligns with HIQA's residents' rights standards, ensuring social inclusion, mental stimulation, and enhanced quality of life.

Time-bound:
• Monthly reviews of activity programs will take place to ensure continuous alignment with resident interests and well-being goals.
• Adjustments and improvements will be implemented following each review cycle.

• A business case has been submitted to the HSE for the recruitment of two additional activity facilitators, enhancing resident engagement and participation in centre activities.
• Until recruitment is finalised, unit-specific activities will continue to be organised on an ongoing basis to ensure continuity in engagement opportunities.
• Current facilitators and staff will continue delivering structured activities at the unit level.
• Alternative engagement methods (e.g., resident forums, feedback sessions) will be used to maintain participation in centre decisions.
• This initiative aligns with HIQA's person-centred care principles, ensuring residents actively contribute to the organisation of their care environment.
Time-bound:
• A review of resident participation and feedback will be conducted by 31st May 2025, assessing engagement levels and identifying areas for improvement.
• Adjustments will be made based on feedback to further enhance resident consultation and involvement.

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(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	28/04/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	21/01/2025
Regulation 19(3)	The directory shall include the information specified in	Substantially Compliant	Yellow	27/01/2025

	paragraph (3) of Schedule 3.			
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.	Substantially Compliant	Yellow	31/03/2025
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	31/05/2025
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	31/05/2025
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	31/05/2025

Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Substantially Compliant	Yellow	31/05/2025
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	31/05/2025
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	30/04/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/04/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire	Substantially Compliant	Yellow	30/04/2025

	prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/04/2025
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	12/02/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant	Substantially Compliant	Yellow	12/02/2025

	whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Substantially Compliant	Yellow	12/02/2025
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	22/01/2025
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	10/02/2025

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	17/02/2025