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:	Farranlea Road Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Farranlea Road, Cork
Type of inspection:	Unannounced
Date of inspection:	10 February 2025
Centre ID:	OSV-0000713
Fieldwork ID:	MON-0045964

About the designated centre

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

Farranlea Road Community Nursing Unit is a designated centre located near the suburban setting of Wilton, Cork. It is registered to accommodate a maximum of 89 residents. It is a two-storey facility with stairs and lift access to the first floor. Farranlea Road is set on a large site with enclosed courtyards and gardens for residents to enjoy. Residents' bedroom accommodation is set out in four units, Oak, Sycamore and Willow each are 25-bedded units accommodating older adults; and Cedar is a 14 bedded unit accommodating younger residents. Each unit is self-contained with a dining room, kitchenette, day rooms, a quiet sitting room and comfortable resting areas along corridors.Bedroom accommodation comprised single, twin and multi-occupancy wards, all with wash-hand basins, and en suite shower, toilet and wash-hand basin facilities. There were additional shower and toilets and a bath room in each unit. Farranlea Road Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, rehabilitation and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	84

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
Monday 10 February 2025	16:15hrs to 21:15hrs	Ella Ferriter	Lead
Tuesday 11 February 2025	09:15hrs to 17:15hrs	Ella Ferriter	Lead
Monday 10 February 2025	16:15hrs to 21:15hrs	Mary O'Mahony	Support
Tuesday 11 February 2025	09:15hrs to 17:15hrs	Mary O'Mahony	Support

What residents told us and what inspectors observed

This unannounced inspection was conducted over one evening and one day, by two inspectors of social services. The inspectors met with a large number of residents during the two day inspection, and spoke in more detail with fifteen residents, to gain an insight into their experience of living in the centre. The majority of feedback from residents was positive and they told the inspectors that the centre was a nice place to live and that they were happy. One resident told the inspectors they would "recommend it to anyone" and complimented the caring nature of the staff. Some residents told the inspectors that it was difficult to get to know staff, as there were frequent changes on a daily basis.

Farranlea Community Nursing Unit is a two story designated centre situated in Wilton, Cork City, which is registered to provide care to 89 residents. The facility has one main entrance and the inspectors saw that there was a full time person available at the reception desk, to greet visitors and ensure they signed in on arrival. The inspectors were informed, at the beginning of the inspection that the person in charge was on planned leave. The assistant director of nursing was deputising in their absence, and facilitated the inspection process.

There were 84 residents living in the centre at the time of this inspection. Inspectors were informed that there were four beds on the Cedar unit currently closed to admissions. Residents' accommodation in the centre is situated over four units, two on each floor. Each of these units had its own dining facilities and sitting rooms. There was also an area on the first floor called " the atrium" where large group activities took place throughout the week. Residents also had access to an oratory on the ground floor and a hairdresser's room, which was seen to be busy on the second day of the inspection.

The layout and design of the premises met residents' individual and collective needs. Residents had free access to internal gardens with seating, paving and planting on the ground floor and upstairs there was an outside balcony area, off one the corridors, which had been decorated with murals on the walls and had numerous plants. The units are named after types of trees, Willow and Cedar on the ground floor and Oak and Sycamore are situated on the first floor. The inspectors found that in general the centre was clean and well maintained, with the exception of some chipped paint in bedrooms and on door frames. Equipment was also observed to be stored inappropriately in residents' bathroom facilities, therefore, these facilities were not accessible to residents. These findings are actioned under regulation 17.

The inspectors saw that residents had access to appropriate storage in their bedrooms for their clothes. Resident's personal clothing was laundered off site. Some residents reported dissatisfaction with the laundry service and described how they were missing pieces of clothing or that they had been damaged. The inspector was informed by residents that the management team had met with them in relation

to this, as soon as they brought it to their attention, and they were looking at alternative options. Some residents' bedrooms were observed to be very personalised with their own furniture from home, mini refrigerators, soft furnishings and pictures. Residents told the inspectors that the staff encouraged them to bring in their belongings from home. Although there was televisions in each bedroom, visibility for some residents in four bedded rooms was limited, due to the location of furniture and overhead hoists. This is actioned under regulation 17.

The inspectors walked through the centre, on the first evening and spent time observing the care provided to residents, talking to residents and staff, and observing the care environment. A large number of residents were observed in the dining rooms having their supper and some residents were in the sitting rooms with visitors or with staff. Residents told inspectors that they always had choice about how and where to spend their day. Staff told the inspectors that there had been improvements since the previous inspection, as there was an additional care attendant on duty in the evening. They stated that this allowed for increased supervision in day rooms, more timely answering of bells when residents needed assistance and medications rounds were interrupted less often.

There were ten residents living on the Cedar unit which accommodates younger adults and all bedroom accommodation is single occupancy. The inspectors observed that there were enhanced staffing levels on this unit, which facilitated staff to spend additional time with residents and support them with their social care. Resident living on this unit had access to a therapeutic kitchen and activities room. The inspector had the opportunity to meet with a resident on this unit who told the inspector that they were excited about moving out to an assisted living apartment in the next few weeks. From a review of documentation and discussion with staff it was evident that the team in Farranlea Road Community Nursing unit had ensured residents' rights were respected and their independence was promoted by supporting them to relocate, to more suitable living environments. Residents on the Cedar unit had their bedrooms very personalised with decor of their favourite football teams, bands and movie stars.

Residents spoken with over the two days were mainly complementary about the food available to them. However, some residents told inspectors the evening meal could be improved, as food was not always appetising and there was not a great choice. From review of the menu and from discussions with staff it was evident that there was a salad on every evening and one hot option. Inspectors observed the hot option on day one did not look appetising and there was a limited choice for residents requiring textured or modified diets. This is further detailed under regulation 18.

The inspectors spent time over the two days observing residents' daily lives and care practices, in order to gain insight into the experience of those living there. The inspectors saw respectful interactions between staff and residents. Staff always asked residents' permission before entering their rooms and knocked on their doors. Residents told the inspectors that they could choose what time to get up from bed and that although staff were sometimes busy, they were well cared for and staff were kind. The inspectors also had the opportunity to meet with six visitors who all

complemented the care their family member received, one visitor telling inspectors that their relative had improved since coming to the centre, due to the input and expertise of the team and the excellent care.

The provision of varied daily activities for residents continued to be a positive focus in residents' lives, and lent structure to their day. Some residents were facilitated to go to day services, or on outings with their personal assistants. There was two members of staff allocated to activities each day. Residents inspectors spoke with were familiar with the various activities on the day of inspection. Over 50 residents were seen to engage in a birthday celebration with a two piece band in the Atrium.

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 on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor the centre's compliance with the care and welfare regulations and to follow up on the previous inspection of the centre of April 2024, which found a lack of comprehensive management systems and poor regulatory compliance in a number of regulations. Findings of this inspection were that the provider had implemented and enhanced their monitoring systems to ensure residents received a safe and better quality service in Farranlea Road Community Nursing Unit. Although improvements in compliance were found on this inspection, some further actions were required with regards to care planning, food and nutrition, complaints management, the premises, the management of restraint and infection control. These findings will be detailed under the relevant regulations.

Farranlea Road Community Nursing Unit is a designated centre for older people operated by the Health Services Executive (HSE), who is the registered provider. There was a clearly defined management structure in place. From a clinical perspective within the centre, care is directed by a suitably qualified person in charge, who had been in the post for approximately five years. They are supported by a management team comprising of an assistant director of nursing, eight clinical nurse managers and a night superintendent. There is also a team of registered nurses, health care assistants, domestic, activities, catering and administrative staff. The person in charge reports to a general manager for older person’s services in the HSE, who the inspectors were informed, is available to the team, for consultation and support on a daily basis. The centre is also supported by centralised departments such as human resources, finance, fire and estates and clinical practice development. An annual review of the quality and safety of the service for 2024 was formulated, which identified quality improvements to be implemented in 2025.

Overall, the inspector found that there were adequate resources in the centre on the day of inspection, in terms of the staffing levels. The provider had increased evening staff resources, specifically the amount of health care assistants on each unit, in response to the findings of the previous inspection. From discussions with staff and residents it was evident that this had a positive impact on residents living in the centre. However, there was an over reliance of agency staff to support the staff roster. Although there was evidence of advanced planning in relation to the staff roster, the centre required the use of agency staff on a daily basis. This finding is actioned under regulation 23.

The centre had established and strengthened their management systems to monitor the quality and safety of the service provided to residents, in response to the most recent inspection. This was through ongoing audit and collection of clinical data, increased presence of the management team at daily reports and increased staff supervision on the ground. There was also enhanced interaction amongst managers from other community hospitals to share learning. However, inspectors found that on some units where audits were being undertaken, there were not associated action plans formulated to address the findings, this is further detailed under regulation 23.

Although some improvements were noted in staff training since the previous inspection, specifically the monitoring off staff training by managers on each unit, further action was required. Contracted staff were found not to have access to mandatory training and further training was required to care for residents with complex care needs. These findings are detailed under regulation 16. Record management systems consisted of both electronic and a paper-based system. A sample of staff personnel files were reviewed, however, not all were found to contain information required by Schedule 2 of the regulations, as detailed under regulation 24. A vetting disclosure for each member of staff, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021 was obtained prior to commencement of employment.

Incident records were well maintained within the centre and all incidents had been reported to the Chief Inspector, as per regulatory requirements. However, there was not always evidence of learning from incidents such as medication errors and falls, as evidenced on review of records, which is actioned under regulation 23. Policies and procedures, as required by Schedule 5 of the regulations, had been reviewed by the provider at intervals not exceeding three years and were made available to staff. The directory of residents was available for review, however, some information required by the regulations, was not documented.

Complaint records were reviewed and discussed with a member of the management team. It was evident that an effective complaints procedure was in place and this had been updated to reflect the changes to the regulations in March 2023. However, action was required in relation responding to complaints in writing and ensuring all complaints were recorded, which is further detailed under Regulation 34.

Regulation 14: Persons in charge

The centre was being managed by a full time person in charge. They had the necessary experience and qualifications as required by the regulations.

Judgment: Compliant

Regulation 15: Staffing

From an examination of the staff duty rota and communication with residents and staff it was the found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the 84 residents living in the centre. The registered provider has increased the number of staff working in the evening, with the introduction of a twilight shift from 17:00rs to midnight, on three units of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Action was required to ensure staff were appropriately trained, evidenced by the following findings:

- The provider employed an external company on a daily basis, with responsibilities for cleaning the centre. However, from discussions with these individuals it was evident that they were not provided training in fire safety, responsive behaviours or safeguarding vulnerable adults. This is mandatory training as per the centres policy.
- Staff had not received specialist training in caring for a resident with specific conditions, therefore, the inspector was not assured that they had the knowledge and skills to manage this condition.
- Some training for staff in responsive behaviour was out of date and refresher training had not been provided.

Judgment: Not compliant

Regulation 19: Directory of residents

The provider had established a directory of residents for each unit of the centre. However, on two of the four units this was not being updated and maintained to include all information, as outlined in the regulations.

Judgment: Substantially compliant

Regulation 21: Records

One staff member did not have a reference obtained prior to commencing employment in the centre. This is a requirement of the regulation. This was subsequently obtained by the provider, however, the staff member had been working in the centre for a substantial period of time.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place required further strengthening to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored, in particular:

- There was an over reliance on agency staff in the centre due to numerous vacant registered nurse and healthcare assistant positions that had not been filled.
- There was not evidence of learning from incidents occurring in the centre, such as medication errors to ensure that the root cause was understood and that systems could be enhanced to prevent future occurrence.
- Infection prevention and control audits reviewed did not identify that results were scored and tracked to allow for progress or deterioration to be monitored. Surveillance of MDRO colonisation was not comprehensive. As a result, there was some ambiguity among staff and management regarding which residents were colonised with MDROs including Vancomycin-resistant Enterococci (VRE) and (CPE). This meant that staff were unable to monitor the trends in development of antimicrobial resistance within the centre.
- There was a lack of oversight of training and assessment and care planning as identified under Regulation 16; Training and Staff Development and Regulation; 5 Individual Assessment and care planning.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in Schedule 4 of the regulations were notified to the Chief Inspector within the required time frames, as per regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The following required action to comply with the regulation, evidenced by the following findings:

- A review of complaints records found that there was not always a provision of a written response to the complainant. This is required to inform the complaint whether or not their complaint had been upheld, the reasons for that decision, any improvements recommended and details of the review process. This is a requirements of the regulation.
- From discussions with residents it was evident that not all of their verbal complaints were being documented. For example; complaints with regards the laundry service and damage to clothing.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures required by Schedule 5 of the regulations were available to guide staff, for example the policies on use of restraint, fire safety management and end-of-life care. These policies were centre-specific and were up to date with relevant information and national and international guidance.

Judgment: Compliant

Quality and safety

The inspectors found that residents living in Farranlea Road Community Nursing Unit received care and support that was of a good standard. The provider had strengthened the management systems and enhanced oversight of residents' healthcare and addressed issued pertaining to residents rights since the previous inspection. This had resulted in improvements in the quality and safety of care delivery for residents. However, some further actions were required with regards to

care planning, the management of restraint, infection control, food and nutrition and the premises. These will be detailed under the relevant regulations.

The health and well-being of residents was promoted in the centre and residents were given appropriate support and access to health professionals to meet any identified health care needs. Residents had access to professionals such as general practitioners, dietitians, speech and language therapists, and tissue viability services. A physiotherapy and occupational therapy service were situated on-site, which was a particular strength of the service. A review of residents' records evidenced regular general practitioner reviews and timely access to healthcare services. Multidisciplinary meetings took place monthly, where residents care requirements were discussed and planned, which resulted in improved outcomes for residents.

A sample of residents' assessments and care plan records were reviewed. Residents physical, psychological and social care needs were comprehensively assessed on admission to the centre, using validated assessment tools. The outcome of the assessments informed the development of care plans, which provided guidance to staff on delivery of care to residents. However, on review of residents care plans, inspectors found that they were not always updated when the conditions of residents changed. This and other findings are actioned under regulation 5.

There was good evidence of regular review of residents' by a dietitian and timely intervention from speech and language therapy when required. Systems were in place to ensure that residents received correct meals, as recommended by speech and language therapists and dietitians.

From observation and review of documentation, there were arrangements in place to safeguard residents from abuse. The centre had a high use of restrictive practices, specifically bedrails which were found to be allocated to over 40% of residents. Although a comprehensive register of restrictive practices was being maintained on each unit, action was required to ensure risk assessments were appropriately documented and the least restrictive option was always used, as per national policy. This is further detailed under regulation 7.

Residents were consulted about their care needs and about the overall service being delivered. Resident' meetings were held and there was a good level of attendance by residents. Records indicated that issues raised at these meetings were addressed such as suggestions for food and activities. Advocacy services were available for residents and the provider had prepared a residents guide, as per regulatory requirements.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Visiting was not restrictive and their were suitable communal facilities available for residents to meet with their visitors.

Judgment: Compliant

Regulation 17: Premises

Areas to be addressed pertaining to the premises to ensure it complied with Schedule 6 of the regulations included the following:

- There was very limited decor on two of the units in the centre, which made these areas appear clinical as opposed to homely.
- Paint on some doorways and walls of bedrooms was cracked and chipped.
- Equipment such as clinical waste bins and wheelchairs were observed to be stored in communal bathrooms, making these facilities unavailable for residents.
- The inspectors observed one of the external courtyards was not kept clean as over thirty cigarette were disposed of on the ground.
- One resident did not have access to locked storage in their bedroom, which is a requirement of the regulation.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Some residents told the inspectors there was minimal choice available at supper time. This was specifically in relation to the choice of a hot meal. Inspectors observed on the first evening of this inspection the hot meal did not appear appetising and choice was limited for those requiring modified diets. The management team informed the inspectors that they were planning a review of menus as part of their quality improvement plan for 2025.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared and made available to residents a guide in respect of the centre. This contained all information as specified in the regulations.

Judgment: Compliant

Regulation 27: Infection control

While the centre's interior was generally clean on the inspection day, some areas for improvement were identified to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018), evidenced by:

- Some equipment such as crash mats were observed to be damaged, therefore effective cleaning could not be assured.
- A resident with a history of a MDRO was residing in a four bedded room. However, there was ambiguity amongst staff in relation to this. As a result, appropriate precautions may not be in place when caring for this resident.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care planning to ensure that residents' documentation reflected their care requirements and could direct care delivery. For example:

- A resident who required specific care delivery if they experienced an epileptic seizure, did not have sufficient detail in their care plan to direct care.
- A resident who required specific specialised nursing intervention, pertaining to their care did not have this reflected in their care plan.
- Some care plans were not updated when the needs of residents changed. For example; after a review by a speech and language therapist and alteration to the texture of their diet. This could lead to errors in care provision.
- A resident admitted to the centre did not have their care plan formulated within 48 hours of admission. This is a requirement of the regulation.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to access a range of health and social care expertise Where residents required further health and social care expertise, they were supported to access these services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Action was required to comply with this regulation evidenced by the following:

- There was a high usage of bedrails in the centre with 40% percent of residents being allocated them. On review of documentation associated with their use it as evident that in some instances bedrails assessments were not being completed in full prior to their use. Therefore, the inspectors were not assured that they were used in line with the centres policy.
- A resident allocated a wander guard did not have an appropriate risk assessment to support this restrictive practice.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors were satisfied with the measures in place to safeguard residents and protect them from abuse. Safeguarding training was up to date for staff. Any safeguarding issues identified were reported, investigated and appropriate action taken to protect the resident. A safeguarding policy detailed the roles and responsibilities and appropriate steps for staff to take should a concern arise. The centre had access to the local safeguarding team to advise and support them with care delivery.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that residents' rights and choices were promoted and respected in the centre. Residents had good opportunities to participate in social activities in line with their interests and capabilities. Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Farranlea Road Community Nursing Unit OSV-0000713

Inspection ID: MON-0045964

Date of inspection: 11/02/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All external company staff has been instructed to submit evidence of safeguarding training to senior management by 10.04.2025. • All external company staff will attend fire safety training on 31/03/25. • All external company staff will be scheduled to attend in house responsive behavior training during March and April. • All external company staff training needs will be monitored by the external company supervisor and senior management. The company has been issued instructions regarding the mandatory training requirements for all new employees. • Specialist training for staff has been sourced and staff will attend upcoming training in May. • All staff identified as requiring responsive behavior training will attend in house training. Responsive behavior training courses are conducted monthly and commenced in March. It is anticipated that we will achieve 100% compliance by August 2025.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: All four units have updated the Directory of Residents and this will be kept as a live document by the CNM. This will be updated and submitted to the DON weekly.	

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• The staff member's reference had been updated.

• A staff member has been assigned to comprehensively audit all staff files to ensure they are compliant with the regulation.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• All Vacant Posts are identified and business cases have been submitted for replacement.
• HCA interviews have been scheduled for early April 2025.
• A QPS committee will be established in April to determine the root cause of the medication errors. All monthly NIMS reported will be reviewed to trend errors and identify appropriate actions. The CNMs will share incidents and learning to all staff. Medication incidents discussed at CNM meeting on March 11th.
• An Infection Prevention and Control Committee will be established in Farranlea CNU in April with input from the two IPC link nurses to follow up audit action plans and share learning. The monthly MDRO Audit will be shared with all staff at ward level
• All MDROs colonisation and active cases will be added to all wards weekly KPI from 07.04.2025.

• CNM2 on all four wards have been instructed from 11.02.2025 to ensure that all residents with a history of known MDRO colonisation or active cases is documented in the care-plan. This will be communicated daily at hand over and safety pause to all staff on duty. MDRO colonization and active cases will be monitored as part of the CNMs weekly KPI.

• Specialist training for staff has been sourced and staff will attend upcoming training in May.
• All staff identified as requiring responsive behavior training will attend in house training. Responsive behavior training courses are conducted monthly and commenced in March. It is anticipated that we will achieve 100% compliance by August 2025.
• An audit was conducted on 15.03.2025/16.03.2025 by a senior enhanced nurse on all 4 wards to ensure that all residents with a history of seizures or with prescribed seizure medication has a care plan in place which reflects their specific care needs in the event of a seizure. The results were shared with the resident's assigned nurse and a re-audit

will be completed on 29/03.2025/30.03.2025.
• An audit has was conducted on 15.03.2025/16.03.2025 by a senior enhanced nurse on all 4 wards to ensure that all residents who require a specific nursing intervention as identified by the inspector pertaining to their care, has this specific intervention reflected in their care plan. The results were shared with the residents assigned nurse and a re-audit will be completed on 29/03.2025/30.03.2025.

• These are additional to the scheduled monthly documentation audit reviewed by the CNM.
• CNM were instructed at a senior management meeting on 11.03.2025 to update all residents care plan in respect any changes or alteration to care or diet following review by GP, SALT, Dietitian or other members of the Multidisciplinary team on the day of review, in the absence of a CNM this task will be completed by the senior nurse on duty. The CNM on each unit will submit a fully completed care plan to the senior management office 48 hours after admission as per regulation.
• A retrospective audit will commence on 29.03.2025 by a senior enhanced nurse of all admissions over the last three months to assure the service of compliance.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• FCNU will ensure all staff undertake the relevant complaints management training on hseland to ensure full awareness and proper implementation of Your Service Your Say – The Management of Service User, Feedback for Comments, Compliments and Complaints – HSE Policy 2017 - and particularly to appropriately document recordings, including written outcomes, on complaints defined under the legislation for investigation in accordance with the requirements of the relevant statutory instrument SI652/2006 as set out in that policy.
• All CNM will instruct staff to document and record all verbal complains, document actions taken and learning outcomes.
• All complaints are monitored by senior nurse management.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Person centered projects are in progress in all 4 wards which endeavor to make the ward environment more personal and homely.
• Painting to commence in all for units from April.

• Clinical bins and wheel chairs have been removed from the communal bathroom and alternative storage options for wheelchairs is currently being explored for the building as a whole.
• Maintenance department will provide a grounds man in March to check and maintain all external areas and provide appropriate cigarette bins for residents.
• Locked storage has since been provided for this resident.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Input has been sought from senior SLT and dietician and the catering team have been instructed with the following: a) it will be explicitly stated that there will be a choice of veg/salad for main meals on the menus b) an additional choice has been added to the tea time options and advice has been given on suitable modification of these options c) ability to modify additional dietary option has been successfully achieved and alternative developed d) new menus will be drafted to reflect the changes and displayed e) additional modified options have been sourced to extend the options for modified diets.
• During the month of June, Dietetic Masters students will undertake their catering placement in Farranlea. Under the supervision of the staff dietician they will conduct a menu analysis on modified diet options.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• All damaged crash mats have been identified and phased replacement has begun.
• All damaged equipment will be identified daily and highlighted at daily safety pause. The appropriate repair engineer will be contacted by the CNM or senior nurse for repairs and removed from use. This will be documented and monitored at the daily safety pause in the broken/damaged equipment section.

• CNM2's on all 4 wards have been instructed from 11.02.2025 to ensure that all residents with a history of known MDRO colonisation is documented in care-plan and communicated daily at hand over and safety pause to all staff on duty. This will be monitored as part of the CNMs weekly KPI.

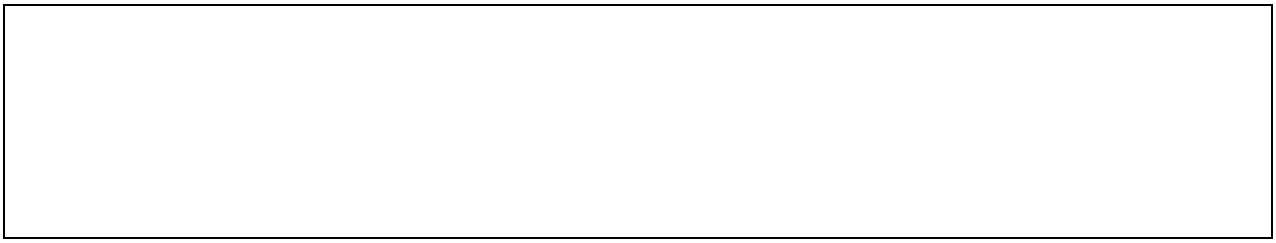
Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
An audit was conducted on 15.03.2025/16.03.2025 by a senior enhanced nurse on all 4 wards to ensure that all residents with a history of seizures or with prescribed seizure medication has a care plan in place which reflects their specific care needs in the event of a seizure. The results were shared with the resident's assigned nurse and a re-audit will be completed on 29/03.2025/30.03.2025.
• An audit has was conducted on 15.03.2025/16.03.2025 by a senior enhanced nurse on all 4 wards to ensure that all residents who require a specific nursing intervention as identified by the inspector pertaining to their care, has this specific intervention reflected in their care plan. The results were shared with the residents' assigned nurse and a re-audit will be completed on 29/03.2025/30.03.2025.

• CNM were instructed at a senior management meeting on 11.03.2025 to update a residents care plan in respect any changes or alteration to care or diet following review by GP, SALT, Dietitian or other members of the Multidisciplinary team on the day of review, in the absence of a CNM this task will be completed by the senior nurse on duty.
• The CNM or senior nurse on duty on each unit will submit a fully completed care plan to the ADON or delegated senior manager to in charge on the day 48 hours after admission review for completion as per regulation.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• All residents identified in the restraint register will have their care plan reviewed by the CNM using the restrictive practice audit to identify any deficits in bedrail assessments. All bed rail assessment found non-compliant will be completed. This will be completed by 30.04.2025.
• All CNMs were instructed at the senior management meeting on 11.03.2025 to review all residents care plans and confirm that comprehensive fully completed assessments are in place. Care plans with incomplete assessments will be referred to the assigned nurse to update. Additional restrictive practice audits will be conducted by the CNMs to provide the service with assurance that restrictive practice is only used in compliance with National and Local Policy.
• The resident has been reassessed using the dewing assessment and no longer requires a wander guard the care plan has been update to reflect the change.



Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/08/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/08/2025
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	25/02/2025
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Substantially Compliant	Yellow	25/02/2025

	are wholesome and nutritious.			
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Substantially Compliant	Yellow	25/03/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/08/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/09/2025
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	30/08/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the	Substantially Compliant	Yellow	30/04/2025

	standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	30/07/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's	Substantially Compliant	Yellow	30/04/2025

	individual care plan.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/03/2025
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.	Not Compliant	Orange	31/03/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/04/2025