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:	Heather House Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	St Mary's Health Campus, Gurranabraher, Cork
Type of inspection:	Unannounced
Date of inspection:	06 August 2025
Centre ID:	OSV-0000714
Fieldwork ID:	MON-0039006

About the designated centre

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

Heather House Community Nursing Unit is a purpose built, two storey premises. It is located on the grounds of St. Mary's Health Campus on the north side of Cork City. It was opened in 2011 and a 60-bedded extension was added in 2023. The centre is currently registered to accommodate 60 residents in two units, namely, Poppy and Lily in the new extension as two units in the original building, Daisy and Primrose, are temporarily closed. Lily and Poppy are 30-bedded units. Each unit has its own sitting room, dining room and quiet room. Additional communal space include the quiet visitors' room alongside the main entrance, the prayer room, Glass room, main activities room and the Waterlily games room. Residents have free access to an enclosed garden with seating and walkways and a sheltered smoking area. Heather House 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 is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

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 6 August 2025	08:30hrs to 17:30hrs	Breeda Desmond	Lead
Wednesday 6 August 2025	08:30hrs to 17:30hrs	Laura Kelleher	Support

What residents told us and what inspectors observed

Inspectors met many residents living in the centre and spoke with eight residents in more detail. Residents said that they were happy with the service and that staff were attentive, friendly and kind. Inspectors also met three visitors during the day and they said their relative was very happy in the centre. Inspectors saw visitors relaxing and chatting in the main foyer; other visitors were seen visiting in residents' bedrooms. Observation throughout the inspection showed that staff were respectful, kind and actively engaged with residents; and residents knew staff by name.

On arrival for this unannounced inspection, inspectors completed the centre's risk management procedures which included a signing-in process and hand hygiene. The purpose of the inspection was outlined to the acting assistant director of nursing. The person in charge was on leave but came on site for the inspection. Heather House Community Nursing Unit is a two-storey building situated on St Mary's Campus, Gurranabraher; the campus also accommodates community care, primary care, day services and a minor injuries unit.

The designated centre, currently, has 60 beds open as the other 50 beds are undergoing refurbishment and fire safety remedial works. Primrose unit on the ground floor (GF) of the old building was temporarily closed for refurbishment and was appropriately sealed prohibiting unauthorised entry as well as protection regarding risk associated with dust particles. Daisy (25 bedded) on the first floor (FF) of the old building, also undergoing fire safety works, was accessible on the day of inspection and did not have the same protections in place to ensure the safety and well-being of residents that may wander to that section of the building.

Lily (GF) and Poppy (FF) are two 30 bedded units in the new extension – this section is currently open. The new main entrance is wheelchair accessible and opens into an expansive hallway with the new extension to the right and older building to the left. The family room is located here and has a kitchenette, furnishings and en suite facilities.

Lily and Poppy are self-contained units and all bedrooms are single rooms with full en suite facilities. There were low low beds, pressure relieving mattresses, specialist chairs, and all rooms including the assisted bathroom, have overhead hoists to assist residents when transferring from bed to chair or chair to shower. Orientation signage to rooms such as the day room and dining room was displayed to ally confusion and disorientation.

Residents' bedrooms were decorated in accordance with residents' choice and preference; some had plants, flowers, mementos from home, posters, paintings, soft furnishings and fairy lighting to brighten their bedroom space. Some residents had a mini fridge for their beverages. Outside each bedroom in the new wing there were small presses with glass frontage where residents had mementos such as photographs, soft toys, small ornaments and posters identifying their room. Call

bells were seen to be fitted in bedrooms, bathrooms and communal rooms. Call bells were installed following the findings of the last inspection in the smoking shelter, garden and balcony spaces for residents, staff or visitors to call for assistance if required. Additional toilet and specialist bath facilities are available on each floor. Communal spaces comprise the dining room, small quiet sitting room and a second larger sitting room; these rooms were appropriately decorated with paintings, soft furnishings and ornamentation making rooms homely and welcoming. Murals were painted on walls of woodland and arctic scenes, and residents art work and art work donated by the Mens' Shed was displayed throughout, and looked really well.

Additional communal areas included the Glass room upstairs which is a beautiful space for families to meet with residents in private. On the ground floor beyond the reception area communal space includes the prayer room, the Waterlily social centre with bookshelves with a variety of books and games, and the activities room. The activities room was not currently being used as activities were facilitated on Lily and Poppy; it was envisaged that the activities room would be used when Primrose and Daisy units re-open. Also located on this corridor were administration and nursing administration offices, the hairdressers' room and main kitchen.

The internal courtyard in the new extension could be accessed from several points such as the dining room and quiet room; this space was poorly maintained with a lot of weeds and blue plastic gloves strewn in the flower beds. The smoking shelter was re-located to this courtyard; it had a heater, electronic devise for lighting cigarettes, fire blanket, call bell, and two fire extinguisher (the servicing records for these were out of date since March). Residents could independently access this space with push-button controls, both inside and outside, and one resident was seen to independently access the smoking shelter throughout the day.

Upstairs, there were balconies for residents to sit out and enjoy the fresh air; re-enforced glass was mounted on top of walls here to ensure residents' safety while at the same time allowing for un-obstructed views of the city. One balcony had a protective awning, garden furniture, and looked lovely. As the other balcony did not have an awning, there was no garden furniture here for residents to sit out and enjoy the space. While there were push-button mechanisms to access the balconies from dayrooms, these devices remained inaccessible to residents with mobility needs as they were positioned too far away; access to one was further compromised as there was an exercise bike positioned in front of it.

Inspector observed breakfast and dinner mealtimes. Three residents were seen to have breakfast in Poppy dining room and staff provided appropriate assistance as required. The radio was playing with appropriate channel selected and volume at a pleasant sound. Some residents enjoyed toast and a boiled egg, others had cereal of their choice and bread. The dining room on Lilly was temporarily closed as refurbishment work were in progress due to leaking pipes. The remedial work was due to be completed a fortnight after the inspection, which would enable the residents to return to the dining room again to enjoy a social dining experience. Residents here were seen to have their meals in the day rooms or in their bedrooms. Residents had choice for their main meal, however, when a resident chose not to have soup as a starter, there was no alternative offered. The main

meal was served from 12:40hrs, however, tables were set with glasses of water, orange and blackcurrant at 11:30am; it was an exceptionally hot day and these drink glasses were warm to touch when checked by the inspector. Having drinks poured prior to residents coming to the table also did not allow for residents to change their mind from their routine. While there was a menu board to display the choice of the day, all that was written for starters was 'soup of the day' so residents did not know what was being served. While residents having their meal in the dining room were served their courses separately, residents having their meal in their bedrooms had their dinner and dessert (jelly and ice cream) served together; as it was a really hot day, desserts would not be eaten at an optimum temperature and would possibly have melted.

During the walk about at the start of the inspection, inspectors spoke with one resident in their bedroom enjoying the morning show on TV; other resident spoken with was waiting to be collected to go to an appointment; staff had her music player on and she explained to inspectors that she was listening to Mario Lanza singing; another resident was in their bedroom, enjoying a cup of tea and listening to the radio and explained that he would go to activities later in the morning and was familiar with the activities programme of the day.

An external company provided activation on each unit on a daily basis, Monday to Friday. A variety of activities was seen on each unit throughout the day including one-to-one and group interaction such as quiz, games, sing-songs and reading. Interactive 'magic' tables were in the main day rooms on Poppy and Lily that displayed games and an assortment of scenes which enhanced interaction and co-ordination of residents, in particular, people with a cognitive impairment.

The sensory room was a lovely calm space where residents could enjoy relaxed sensory time. While there was large occupational therapy room, with fully equipped kitchen, the room had not been furnished with tables or chairs to enable activities such as baking for example. This was the same finding from the previous inspection in 2024. Call bells were activated throughout the day, but the noise of call bells on Lily was unpleasant; residents were heard commenting on this as well.

A safety pause was facilitated on a daily basis on each unit. One inspector attended this and comprehensive information-sharing was observed. Care staff provided up-to-date information regarding residents' status and the charge nurse informed staff of additional care needs of residents.

Emergency evacuation floor plans were displayed on each unit and had points of reference, emergency exits and fire equipment identified. An easy accessible complaints procedure was displayed throughout the building.

Hand sanitisers were available on corridors, and residents' bedrooms had clinical handwash sinks. Dirty utility rooms were securely maintained as sharps containers and clinical waste were stored here.

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

Capacity and capability

This was a one-day unannounced inspection conducted by inspectors of social services to inform the application to renew registration of Heather House Community Nursing Unit (HH CNU), and to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older people) Regulations.

Overall, the inspection found that while there was a defined management structure in place, there were changes to the management structure since the last inspection as the CNMs posts on each unit were currently vacant. The senior managers with responsibility, authority and accountability for the service, outlined in the centre's statement of purpose, were not named as persons participating in management on the centre's registration.

The inspector reviewed the actions from the previous inspection and found that some actions were completed which included some fire safety works and infection control issues. Further action was required to comply with the regulations in relation to the premises, fire safety, policies and procedures, food and nutrition and governance and management. These will be detailed under the relevant regulations of this report.

Heather House Community Nursing Unit is a residential care setting operated by the Health Services Executive (HSE). The centre is currently registered to accommodate 85 residents but this number was reduced to 60 residents due to ongoing fire safety works in two of the units in the older original building. Applications to vary conditions of registration to regularise the bed occupancy were being progressed at the time of the inspection. Regarding the management structure, the person in charge worked full-time in the centre and was supported by a newly appointed acting assistant director of nursing (ADON) and three Clinical Nurse Managers 3 (CNMs) on night duty; previously there were three CNMs 2 on day duty but these posts were vacant at the time of inspection.

At a more senior level, governance was provided by a general manager for older persons, who represented the registered provider. The service also had support from centralised departments such as finance, human resources, fire and estates, and practice development. There was evidence of communication via quality and patient safety meetings to discuss all areas of governance, and liaise with other person in charges as part of collegial support and information-sharing.

The inspector found that the levels of staff, at the time of inspection, were more than sufficient to meet the care needs of the current number of residents living in

the centre. As previously stated, CNM posts were vacant**;** senior enhanced nurses were rostered on duty each day and were super-numery on the duty roster.

There was a schedule of clinical audits in place in the centre to monitor the quality and safety of care provided to residents. However, issues identified on inspection in relation to complaints, care records and residents' feedback for example, were not identified as part of the audit process to enable quality improvement. Evidence of this is detailed throughout the report and actioned under the relevant regulations.

Documents requested were made readily available to inspectors throughout the inspection. The directory of residents was updated during the inspection to include the requirements of Schedule 3 of the regulations. A review of resident' records and minutes of residents' meetings were examined and while some incidents were appropriately recorded and addressed with appropriate action taken, others were not. A record of complaints was maintained, and while issues were followed up, some complaints made were not identified as safeguarding concerns, and consequently, not followed up as such, and not notified to the Chief Inspector in accordance with regulatory requirements.

Registration Regulation 4: Application for registration or renewal of registration

An application to renew registration of Heather House Community Nursing Unit was timely submitted to the regulator; fees were paid, and the application form and prescribed documentation were received.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was full time in post; he had the necessary qualifications as required in the regulations. He actively engaged with the regulator, was knowledgeable regarding the role and responsibility as specified in the regulations, and engaged in the operational management and administration of the service.

Judgment: Compliant

Regulation 15: Staffing

There were more than adequate staffing levels to the size and layout of the centre:

Each unit (30 residents each) had the following staffing:

Nurses – 07:45am – 20:15pm x 5 daily

Night duty 19:45pm – 8am x 2

HCAs – 07:45am – 19:45pm x 5 daily

07:45am – 17:30pm x 1 daily

Night duty x 2

Pantry - 07:45am – 18:00pm x 1

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix was reviewed and mandatory training and other training was provided to staff with additional training scheduled to ensure training remained current.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was updated on inspection to include the occasions when residents were temporarily absent from the centre when transferred to another care facility such as acute care, as specified under paragraph 3 of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

A sample of Schedule 2 records to be maintained in relation to the person in charge and all staff were examined and the following deficits were identified:

- there were unexplained gaps in the employment history in one staff file
- there were no dates associated with the employment history of another file

- there was just one reference for one staff [regulatory requirements specify that two written references are required].

Judgment: Substantially compliant

Regulation 23: Governance and management

Senior managers with responsibility, authority and accountability for the service, outlined in the centre's statement of purpose, were not named as persons participating in management on the centre's registration.

Management systems, as required under Regulation 23(d), were not sufficiently robust to ensure the service provided was safe, appropriate, consistent and effectively monitored, specifically:

- lack of oversight of some Schedule 5 policies and procedures as these were not updated following the findings of the last three inspections to ensure regulatory compliance
- the systems in place to ensure effective monitoring of the service were not consistent to enable quality improvement as evidenced throughout the report, such as the maintenance of staff files and oversight of premises issues.

Regarding risk:

- it was possible to access Daisy unit during the inspection, this unit was under refurbishment with building construction in progress; this was remedied on inspection whereby the person in charge liaised with the project manager to ensure builders only accessed the building from an external doorway and secured the entrance internally.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required updating, as follows:

- to include the total staff complement
- information regarding how the privacy and dignity of residents is respected
- the floor plans to be updated to reflect the centre**.**

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of complaints, residents' notes and minutes of residents' meetings showed that the appropriate notifications were not submitted to the Chief Inspector:

- two records included information of inappropriate interaction by staff with residents; this was not reported as a safeguarding concern and the associated NF06/NF07 were not submitted,
- resident's notes reported that a resident had left the building without the knowledge of the care staff on the unit and the associated NF05 was not submitted.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A number of Schedule 5 policies and procedures had not been updated to reflect current legislation and National Standards, this was a repeat finding from previous inspections:

- the temporary absence and discharge policy did not include information relating to the temporary absence for treatment to another healthcare facility – this was a repeat finding
- the admissions policy was out of date; it was last reviewed in 2019. This was identified in the previous inspection compliance plan which stated it would be updated however this was not completed, resulting in this being a repeat finding.

Judgment: Not compliant

Quality and safety

Overall, residents were supported and encouraged to be independent and have a good quality of life in Heather House CNU. Residents had access to social activities, personal assistants, and health professional services. Residents spoke positively about the care and attention they received. Notwithstanding the positive findings, action was required in relation to the premises, fire safety, food and nutrition. These areas are further detailed under the relevant regulations.

The inspector attended the safety pause in the afternoon; this was a comprehensive information-sharing catch up to ensure staff had up-to-date information on the

current status of residents; staff that provided care during the morning, in turn, gave updates on the residents care needs. Residents had good access to general practitioner (GP) services, to specialist health professionals and out-patient services. Residents' records showed that comprehensive pre-admission assessments were carried out for each resident. Residents' nutritional and hydration needs were assessed with monthly weights as part of their nutritional oversight. A sample of residents' assessments and care plan records were reviewed and these showed mixed findings, which are further discussed under Regulation 5, Individual assessment and care plan.

The temporary absence form was part of the resident's care documentation. It was partially completed in anticipation that a resident might need to be transferred to acute care.They reflected the current status of the resident which may not reflect the status of the resident should they become acutely unwell.

While residents gave positive feedback about the quality of food at meal time, better supervision of mealtimes was required; this and other findings are further outlined under Regulation 18: Food and Nutrition.

The person in charge facilitated residents to have access to supports such as the Irish Wheelchair Association and the Irish Disability Association to promote their independence; residents had access to personal assistants (PAs) to enhance their independence and quality of life.

Residents had access to a variety of activities on a daily basis. An external company was on site Monday to Friday and named staff were allocated to activities on weekends. Residents meetings were facilitated every three months and the person in charge had oversight of residents' meetings. The residents' guide was reviewed and this required updating to reflect the specified regulatory requirements.

Residents who required supportive equipment to communicate were provided with such equipment. Residents were supported to continue to practice their religious faiths, and had access to newspapers, radios and televisions. Information and contact details of advocacy services were displayed. The person in charge facilitated residents to access advocacy services and care documentation supported this evidence.

There was a dedicated family room in the centre to provide families with facilities to be with their relative during their end of life. Specialist palliative care services could be easily accessed if required, for additional support and guidance, to ensure residents' end-of-life care needs could be met.

Fire safety notices were displayed for visitors and the procedures to follow in the event of a fire were prominently displayed in the centre, to guide and inform staff. Inspectors reviewed fire dill and evacuation records, and while these occurred on a monthly basis, they were not comprehensively completed so it could not be assured that evacuations were being completed in a safe and timely manner. This is further detailed under Regulation 28: Fire precautions.

Regarding the premises, further improvements were seen regarding the decoration of the premises since the previous inspection. Storage areas were available facilitating storage of hoists and wheelchairs in discreet locations. While issues were identified in the dining room regarding water leakage, appropriate measures were implemented to address these findings including specialist contractors and infection prevention and control specialists. This room was seen to be appropriately cordoned-off, and inspectors were advised that the due-date for completion of remedial works was two weeks after the inspection. Nonetheless, other issues were identified with the premises and these are discussed under Regulation 17: Premises.

Regulation 10: Communication difficulties

Observation showed that residents' communication needs were responded to in a kind and supportive manner by staff. Residents with additional communication needs had these needs met with specialist communication aids; associated care plans were very personalised and provided detailed information to support individualised care to enable residents' independence.

Judgment: Compliant

Regulation 11: Visits

Visitors were seen coming and going throughout the day. There were no restrictions to visiting. There was ample private space for visitors to meet their relative in privacy such as the family room, Glass room, balconies and seating areas, as well as residents' bedrooms if preferred. Staff were seen to engage with relatives and welcome them to the unit in a friendly and social manner. Visitors spoken with gave very positive feedback about the care their relative received.

Judgment: Compliant

Regulation 12: Personal possessions

Bedroom accommodation in Poppy and Lily comprised single bedrooms with ample space to accommodate a double wardrobe, bedside locker and comfortable bedside chair. Many bedrooms had additional personal storage space such as chest of drawers, shelving units for books and memorabilia. There were no issues raised by residents regarding laundry services.

Judgment: Compliant

Regulation 17: Premises

There were a number of areas that required action to ensure the premises met the needs of residents:

- the secure outdoor courtyard was poorly maintained where walkways and shrubberies were un-kept, with weeds growing and blue plastic gloves strewn around
- the hairdresser room was not adequately ventilated as it did not have a window or mechanical ventilation and required the door to be left open when in use; this room would be uncomfortable for residents should the door be closed,
- the balcony upstairs on Poppy was devoid of furniture so residents were unable to use it or sit out and enjoy the space,
- call bell alarm system on Poppy was loud and intrusive due to a fault in the system. While this had been reported to maintenance three weeks prior to the inspection, they continued to wait for a part to be delivered to fix the fault. During the inspection, residents commented on the unpleasant noise of the call bells,
- while there were push-button mechanisms to access the balconies from dayrooms, these devices remained inaccessible to residents with mobility needs as they were positioned too far away; access to one was further compromised as there was an exercise bike positioned in front of it.

Judgment: Not compliant

Regulation 18: Food and nutrition

Action was required to ensure residents were served their meal appropriately and that residents had choice:

- residents had choice for their main meal, however, when residents chose not to have soup as a starter, there was no alternative starter offered
- the main meal was served from 12:40hrs, however, tables were set with glasses of water, orange and blackcurrant at 11:30am; it was an exceptionally hot day and these drink glasses were warm to touch when checked by the inspector. Having drinks poured prior to residents coming to the table did not allow for residents to change their mind from their routine,
- while there was a menu board to display the choice of the day, all that was written for starters was 'soup of the day' so residents did not know what type of soup was being served

- residents having their meal in the dining room were served their courses separately, however, residents having their meal in their bedrooms had their dinner and dessert (jelly and ice-cream) served together; as it was a really hot day desserts would not be eaten at an optimum temperature and possible would have melted.

Judgment: Substantially compliant

Regulation 20: Information for residents

The residents' guide required updating to reflect specified regulatory requirements, as follows:

- to include the terms and conditions relating to residence in the designated centre
- the current services and premises available to residents.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Action was required to ensure regulatory compliance with Regulation 25 as follows:

- one resident records' reviewed showed that they were temporarily transferred to acute care in March, however, their transfer letter was not available so it could not be assured that all the relevant information about the resident was provided to the receiving hospital to ensure the resident could be cared for in accordance with their current needs
- routinely, the temporary absence form was partially completed at the time of admission in anticipation that a resident might need to be transferred to acute care. Areas completed included the nutritional requirements, cognition, frailty and assistance needed, however, this reflected the current status of the resident and may not reflect the status of the resident should they become acutely unwell. This could lead to errors.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required to ensure fire safety precautions as follows:

While fire dill and evacuations occurred on a monthly basis, the records were not comprehensively completed so it could not be assured that evacuations were being completed in a safe and timely manner, as:

- some records did not detail the number of staff participating in the exercise
- while records detailed the times of evacuations they did not detail the number of residents involved in the simulated evacuation.

In some of the records, it showed that it took staff 1min 30 seconds to respond to the fire alarm, however, this delay was not emphasised as part of quality improvement plan to ensure staff responded in a more timely manner to a fire alarm.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

A sample of prescription, medication administration and controlled drug records were examined. These were seen to be comprehensively maintained and in line with professional guidelines.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure assessments and care planning supported a rights-based approach to care delivery,as:

- one resident's mood and behaviour care plan stated that the resident 'has to trust staff, but the care plan did not detail or provide direction on how staff should gain the resident's trust to prevent communication difficulties and provide assurance to the resident
- the care plan of a resident with additional breathing supports did not detail the supports the resident may require when using the breathing apparatus
- medical histories did not consistently inform the assessment and care planning process to ensure the resident would be cared for in accordance with their needs
- formal re-assessments were not routinely completed in accordance with regulatory requirements.

Judgment: Substantially compliant

Regulation 6: Health care

A review of residents' care records showed they had good access to medical services, specialist services and allied health professionals.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to a variety of activities on a daily basis. An external activities company was on site five days a week and a named member of staff was rostered to facilitated activities on the other days. Residents spoken with were aware of the daily activities programme and chose to attend those of interest to them. There was a coffee shop on campus and residents were taken there routinely when they requested. Residents meetings were facilitated every three months and issues raised were followed up on subsequent meetings.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Heather House Community Nursing Unit OSV-0000714

Inspection ID: MON-0039006

Date of inspection: 06/08/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: To address the deficiencies identified in the staff files, relevant staff are informed of the required actions. • Unexplained Employment Gaps: The gaps identified will be updated - with an estimated date of completion of 16.09.2025. • Missing Employment Dates: The employment dates have been updated. • Insufficient References: The staff member with only one reference has been informed of the requirement to provide a second reference and will have this in place for 16.09.2025. All other staff files are currently being reviewed to ensure compliance. The checklist in place has been updated to ensure all required documentation is received and recorded.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The person who will participate in management of the Designated centre is the Person in Charge, and their Qualifications have already been submitted to the Chief Inspector pursuant to section(i) b (ii).The person in charge is supported by the older Persons Services Cork Kerry Community Healthcare. • All Schedule 5 policies, including the admission and discharge policy (which includes the guidelines for the temporary absence from the facility), have been updated. • The CNM2 recruitment for 3 vacant posts, is in the final stages, which will allow for effective monitoring of the service to support quality improvement.	

• The Director of Nursing/Assistant Director of Nursing will oversee the maintenance of staff files, using the checklist that has been introduced, and address issues related to the premises. • Maintenance staff advised to ensure that the Daisy access is kept closed at all times and can only be accessed from the outside by authorised personnel. Senior management will oversee this on a daily basis and a check list in place. **The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.**

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • The Statement of Purpose has been updated to include the total staff complement and information on how the privacy and dignity of the residents is respected. This document was submitted to HIQA on August 14, 2025. • Additionally, the floor plans have been updated to accurately reflect the centre and were also submitted on August 14, 2025.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: NF06 and NF07s were submitted following the inspection and have been reported to the Safeguarding team. Appropriate management responses have addressed issues raised with the relevant staff. • A monitoring process of all incidents is now in place with supporting documentation that will guide decisions to ensure the appropriate pathway is followed in relation to any notifiable incidents. The Director of Nursing/Assistant Director of Nursing will review all incidents on a daily basis. • Regarding the incident where a resident left the building, NF05 was submitted following inspection. However, after investigating, it was determined that this was not an absconsion; instead, the documentation did not fully account to the incident.	
Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • The admission and discharge policy (including temporary absence from the facility) has been updated.

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The courtyard has been well-maintained and is presentable for the residents since 07/08/2025. A Gardener from Estates will maintain the garden weekly, going forward. • The ventilation in the hairdresser's room will be addressed as part of the Daisy project. We are awaiting a completion date from the estates. In the meantime, the door will continue to be left open for ventilation. • Furniture for the balcony area is in the process of being ordered. • The fault with the call bell system has been addressed by the Maintenance Department and periodic checks are in place by the nurse in charge. • The room divider has been moved to the other side of the room, and the exercise bike has been relocated. This will make the push-button mechanism accessible to residents with mobility needs.	

Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: • Through safety pauses and handovers, the staff is informed about the importance of providing choices during meal times. Daily menu options are available, and the head chef has confirmed this. • Staff have been reminded to clearly write the menu board’s content. For example, instead of just labelling it as “soup of the day,” the specific type of soup will be mentioned. • Staff are advised not to serve drinks or meals if residents are not at the table and a choice will be offered to the resident. • When serving meals in the bedroom, staff are reminded to avoid serving all courses at once, as this may prevent residents from eating their meals at the optimal temperature. • The nurse in charge or the DON/ADON will complete spot checks and ad hoc audits.	

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents: • The updated resident's guide now includes the current services and premises available to residents and has also been updated to include the Terms and Conditions.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents: • The admission and discharge policy, which includes guidelines for temporary absences from the facility, has been updated. • Transfer documentation is now completed using Form 249A, which replaces the national transfer record. • Staff are advised not to pre-fill this form, as it is a single-page document designed to provide concise up to date information, at the time of transfer. • Staff are also reminded to file a copy of the transfer document and any other documentation that will assist the resident's transfer, in the care plan following the transfer.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • During safety pauses and staff meetings, staff members are advised about completing the fire drill evacuation report thoroughly. • This report will include the number of staff who participated, the number of residents involved, any issues identified and addressed, and plans for quality improvement. • The CNM3 and DON/ADON will review the report following the drill.

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:
• All resident care plans and assessments are to be regularly reviewed/ four monthly by the staff nurses and audited by the CNM3s. All staff have completed Care Plan training.
• Documentation audits have been completed by the service and will continue as needed.
• The care plans address identified issues related to how staff can build trust with residents to minimise communication difficulties. They also outline the support residents require when using a breathing apparatus.
• Additionally, staff are advised to consider each resident's medical history when updating the care plans.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2025
Regulation 18(1)(a)	The person in charge shall ensure that each resident has access to a safe supply of fresh drinking water at all times.	Substantially Compliant	Yellow	07/08/2025
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	07/08/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food	Substantially Compliant	Yellow	07/08/2025

	and drink which are properly and safely prepared, cooked and served.			
Regulation 20(2)(a)	A guide prepared under paragraph (a) shall include a summary of the services and facilities in that designated centre.	Substantially Compliant	Yellow	10/09/2025
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	10/09/2025
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	16/09/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/12/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Yellow	30/12/2025

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	07/08/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	11/08/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	11/08/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals,	Substantially Compliant	Yellow	11/08/2025

	that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	11/08/2025
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	14/08/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	07/08/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on	Not Compliant	Orange	15/08/2025

	the matters set out in Schedule 5.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	15/08/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	11/08/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	11/08/2025

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	11/08/2025