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:	St Camillus Nursing Centre
Name of provider:	Order of St Camillus
Address of centre:	Killucan, Westmeath
Type of inspection:	Unannounced
Date of inspection:	10 April 2025
Centre ID:	OSV-0000098
Fieldwork ID:	MON-0042729

About the designated centre

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

St. Camillus Nursing Centre was established in 1976 and is registered for a maximum capacity of 57 residents, providing continuing, convalescent, dementia, respite and palliative care to male and female residents, primarily over 65 years with low to high dependency needs. The centre is located on the outskirts of Killucan in Co. Westmeath, close to where four counties meet. All accommodation and facilities are at ground floor level and are well maintained. A variety of communal facilities for residents' use are available. A number of sitting rooms, a quiet room, a visitor's room and seated areas are available. Two dining rooms are located at the front of the building, with one adjoining the main kitchen. The layout and design of both dining rooms provided good outlooks and views of well-maintained gardens and the main driveway. A smoking room, hairdressing room and laundry facility are included in the facilities within the centre. Residents' bedroom accommodation consists of a mixture of 42 single and eight twin rooms. An end-of-life single room for those sharing a bedroom is included in the layout, and two single bedrooms are dedicated to residents with palliative care needs. Some bedrooms have en-suite facilities, while others share communal bathrooms. The centre is connected by a corridor to a splendid chapel where mass is celebrated daily and where the wider community come to meet residents. The service aims to create a caring, safe, and supportive environment where residents feel secure, have meaningful activity, and are encouraged to live life to the fullest while meeting their needs. Family involvement is supported and encouraged. Staff will have appropriate training and the necessary skills to ensure care is tailored to each individual during their stay and up to the end of life.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 10 April 2025	09:15hrs to 17:00hrs	Sarah Armstrong	Lead
Friday 11 April 2025	09:30hrs to 14:30hrs	Sarah Armstrong	Lead
Thursday 10 April 2025	09:15hrs to 17:00hrs	Catherine Rose Connolly Gargan	Support
Friday 11 April 2025	09:30hrs to 14:30hrs	Catherine Rose Connolly Gargan	Support

What residents told us and what inspectors observed

This unannounced inspection was completed over two days. On arrival at the centre, the inspectors met with the person in charge and were accompanied by members of the centre's management on a walk around the centre. This gave the inspectors an opportunity to meet with residents and staff and to observe practices and residents' experiences of living in the centre. The person in charge (PIC) demonstrated the works progressed to address fire safety in the centre and works completed to upgrade the residents' lived environment since the last inspection in November 2024, including. Completion of the installation of a shared shower between two single bedrooms to meet residents' needs ensured that all residents could now access shower and toilet facilities in their bedroom en-suite or within close proximity to their bedrooms.

This designated centre is located a short distance outside Killucan village, and the premises are surrounded by mature gardens. St Camillus Nursing Centre has a religious ethos, and residents told the inspectors that they valued having the opportunity to attend a daily Mass and to visit the large adjoining church, as they wished. On both mornings of this inspection, residents were observed by the inspectors either walking independently or being supported by staff to the church for a morning Mass. The inspectors observed that the residents' lived environment was warm, spacious and bright, and there was a relaxed atmosphere in the centre. Residents' bedrooms and communal accommodation were on the ground floor level. Residents could independently access a large enclosed courtyard from a number of doors along the corridors. The courtyard was designed to support residents' safe mobility and comfort. Raised beds containing flowers, shrubs and small trees placed along the paths, a large central sculpture and a variety of garden ornaments and outdoor seating in the enclosed courtyard provided residents with points of interest and supported them in enjoying this outdoor area.

On both days of this inspection, the atmosphere was calm and unhurried. The environment was warm and bright, with an abundance of large windows in both communal areas and residents’ bedrooms. The inspectors observed that this facilitated natural light to enter the residents' living environment and provided beautiful views of the grounds and surrounding fields. In general, residents’ bedrooms and communal areas were observed to be visibly clean and tidy. Residents’ bedrooms were of a good size and laid out to meet each resident's needs. The inspectors observed that residents' bedrooms were personalised with their personal belongings, such as their family photographs and various soft furnishings. There was a variety of communal rooms and sitting areas available for residents. The communal rooms were spacious and decorated with traditional furniture and ornaments that were familiar to the residents. One resident told the inspectors that the decor added a “homely feel” to the centre that helped to make them 'feel comfortable'.

Although there was a spacious sitting room with a fireplace, piano, television and comfortable seating for residents with views of the surrounding countryside, it was not used by the residents. The inspectors observed that the majority of the residents spent their time in two on-corridor communal sitting areas or in the dining room on both days of the inspection. The inspectors observed that there was a lot of staff and visitor traffic on the corridors. This created a lot of associated background noise, and as these seating areas were not structurally separated from the circulating corridors, the noise impacted on residents' comfort with watching and listening to the televisions operating in both areas. The inspectors also observed that a number of residents in one of these sitting areas were seated directly below a wall-mounted television, which meant they could not see the television. Additionally, a number of the residents were being assisted by staff with eating their meals or were sleeping in these on-corridor sitting areas, while other residents, staff and visitors were passing on the corridor alongside or directly through areas. Due to the location of these sitting areas, there were times when it was noisy, and there was a lot of foot traffic passing through. Inspectors observed that the most of the of the residents did not have any interest in watching television. One resident told the inspectors "I'm sick of TV", whilst another told inspectors "I never watch it". Other residents who spoke with the inspectors said they did not 'do any activities', 'not interested', 'nothing much to do here' and 'I occupy my time by myself'. Many of the residents told the inspectors that they 'liked going to Mass', 'praying the rosary' and 'listening to their radio'. The Mass and other services in the church were streamed via a webcam service to facilitate residents who were unable to, or did not wish to attend the centre's church, to participate in these services in their bedrooms.

There was a schedule of activities displayed in the centre; however, the social activities available were limited to one social activity each day. A small number of residents attended the activities taking place in the dining room on each day. The inspectors observed that three residents attended the arts and crafts activity on the first day, and four residents joined by members of the local community, attended the card game on the second day of this inspection. The inspectors observed that an alternative social activity was not offered for the other residents at this time. There was a high reliance on television viewing, and programmes shown were not always aligned with residents' interests. A number of residents were observed to be sleeping in chairs at all times of the day in these areas. One resident told inspectors that they "find the day long". Another told inspectors that they "love the exercise, but it is only on once a week". In speaking with residents and staff, inspectors found that staff responsible for residents' social activities also had additional responsibilities such as responding to the front door bell, meeting with visitors and assisting with meals. This meant that staff responsible for coordinating residents' social activity programme were not always available to residents and could not ensure that residents' social care needs were being met, and this will be discussed further under the relevant regulations in this report.

Meals were mostly offered in the dining room, where the inspectors observed residents engaging in conversation with each other during their lunchtime meal. Staff were providing support and encouragement to those who required it. Residents told inspectors that the food was "very good" and 'always lovely and tasty'. Staff supported residents to make menu choices, and alternatives to the menu offered

were available, if preferred. However, the inspectors observed that not all residents were afforded equal opportunities in respect of their meal time experience. A small number of residents were not afforded an opportunity to attend the dining room for their meals and were observed to eat their meals in the on-corridor communal sitting areas. This meant that some residents spent their whole day in this same area with no opportunity to enjoy a change of environment.

Staff and residents knew each other well, and they comfortably engaged together in conversations during care procedures. However, the inspectors observed that staff remained with and were available to meet residents' needs for assistance.

Residents told the inspectors that their general practitioner (GP) visited them whenever they needed medical care without delay.

Residents said that they felt very safe and secure in the centre and that they would speak to an individual staff member or their relatives if they had any concerns or were dissatisfied with any aspect of the service they received.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each sections.

Capacity and capability

The purpose of this unannounced inspection was to monitor the registered provider’s compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 as amended and to follow up on progress with completing the actions the provider committed to in their compliance plan following the last inspection in November 2024. Inspectors also followed up on the notifications submitted to the Chief Inspector since the last inspection in November 2024.

Although, there was evidence that some improvements had been made following the previous inspection in November 2024, many of the actions committed to by the provider in the compliance plans from the last two inspections in March and November 2024 were not satisfactorily completed within planned timescales and were found non compliant with the regulations again on this inspection. This inspection found that the provider had not taken adequate action to address fire safety in the designated centre, and the findings of this inspection required urgent action by the provider to ensure residents were protected from the risk of fire and that they would be safely evacuated in the event of a fire in the centre.

Significant improvements in the provider's oversight and management continue to be necessary to bring a number of the regulations into compliance, and to ensure

that the service provided for residents is safe, appropriate, consistent and appropriately monitored.

The provider of St. Camillus Nursing Centre is the Order of St. Camillus, which is an unincorporated body, represented by a senior member of the order, who was unavailable on the days of this inspection. The person in charge is also a member of the order, and they facilitated the inspection with support from a members of the centre's local management team.

There were no staff vacancies at the time of the inspection. As found on the last inspection, there continued to be two staff nurses on duty, and two clinical nurse managers during the day, and two staff nurses on duty during each night. In addition, there were 10 care staff on day duty until 16.00 hours and nine care staff until 20.00 hours. The number of care staff was reduced to three from 20:00 hours until 22.00 hours and then to two care staff from 22.00 hours to 08.00 hours. There was sufficient housekeeping and catering staff on the day of the inspection. Maintenance staff worked with the external contractors to complete the fire safety improvement works that were ongoing in the centre.

The core staff team were supported by 10 volunteers from the local community who organised a number of social activities for residents, including bingo, card games and a mobile shop. Volunteers also supported staff with bed-making and assisted residents to attend the centre's on-site chapel for the daily Mass or for quiet reflection. Staff and volunteers worked well together and demonstrated cooperation and flexibility in their work, which helped to create a pleasant environment for the residents. However, the inspectors found that supervision of staff did not ensure the provider's own policies and procedures were being consistently implemented, and the required standards of care were not being provided for residents. Evidence was not available on this inspection that the provider had reviewed the roles of staff with responsibility for coordinating residents' social activities and completing front-of-house services, and this was impacting on residents' social care provision.

The person in charge maintained a record of all staff training, and staff were facilitated to attend mandatory and professional training. Although the provider had arranged training for staff with responsibility for coordinating residents' social activities programme, this training had not commenced at the time of the inspection, and staff did not demonstrate adequate skills with facilitating a meaningful social activity programme that was suited to each resident's needs. Training had commenced to give staff appropriate skills and knowledge in management of residents who experienced responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment.)

The provider's quality assurance processes continued to require improvement to ensure that all deficits in the quality and safety of the service were identified and that effective actions were taken to address the deficits found. As a result, this inspection found that many of the actions the provider committed to in their

compliance plan were not implemented, and a number of the regulations were found non-compliant with the regulations again on this inspection.

Regulation 15: Staffing

The provider did not ensure that the skill-mix of staff was appropriate having regards to the needs of the residents, assessed in accordance with Regulation 5.

While the provider had recruited additional staff to provide activities and front-of-house services, the inspectors were not assured that residents were adequately supported by staff to participate in meaningful social activities to meet their interests and capacities, and did not demonstrate appropriate knowledge and skills in relation to meeting residents' social care needs. This is a repeated finding from the last inspection in November 2024.

Judgment: Not compliant

Regulation 16: Training and staff development

The staff who spoke with the inspectors were not clearly able to describe their roles and responsibilities in relation to providing a programme of meaningful social activities for the residents. Furthermore, they did not have access to appropriate training in relation to this aspect of their role. As a result, the inspectors found again on this inspection that the limited social activities available did not ensure that all residents who wished to participate in social activities had access to meaningful social activities in line with their preferences and capacities.

In addition, inspectors observed that staff were not appropriately supervised according to their role. As a consequence, staff were not consistently implementing the provider's own policies and procedures in order to ensure care and services were consistently provided to the required standards. This was evidenced by inadequate practices found in the following areas: infection prevention and control practices, assessment and care planning documentation, use of bedrails and fire door checking. These findings are discussed further under the relevant regulations in this report.

Judgment: Not compliant

Regulation 19: Directory of residents

A directory of residents in the centre was maintained and included all information pertaining to each resident as specified by the regulation.

Judgment: Compliant

Regulation 21: Records

Records as set out in Schedules 2, 3 and 4 were kept in the centre and were made available for inspection. A sample of four staff employment files were found to contain all required information. Records were stored safely and the policy on the retention of records was in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had failed to provide adequate resources to ensure that necessary fire safety works were completed as committed to in the compliance plans submitted following the last two inspections in March and November 2024. As a result, the designated centre remained non-compliant in a number of the regulations, and this was negatively impacting on the quality of life and safety of the residents.

The provider's quality assurance and oversight systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by the following findings;

- The system for staff training and supervision of staff required review, as evidenced under Regulation 16: Training and Staff Development.
- The provider's policies and procedures were not being consistently implemented to ensure the safety, well-being and rights of the residents. The inspection findings are set out under Regulation 7: Managing behaviour that is challenging, Regulation 8: Protection and Regulation 9: Residents' Rights.
- The provider had not ensured that residents had opportunities to participate in meaningful social activities to meet their needs. This is discussed under Regulation 9: Residents' Rights.
- Assessment and care planning procedures were not implemented in line with the provider's own policy and procedures and the requirements of the regulations. As a result, the standards of residents' care documentation were not adequate, and it posed a risk that relevant information regarding each resident's needs and care interventions would not be available to staff. These findings are discussed further under Regulation 5.

- Management of risk posed by residents' responsive behaviours did not ensure that all residents were appropriately safeguarded from risk of harm. The inspectors' findings are discussed under Regulation 7: Managing behaviour that is challenging and Regulation 8: Protection.

The registered provider's oversight and management of risk in the centre was not effective regarding the following;

- While the inspectors acknowledged that a number of works were completed to address the significant risks to residents' fire safety, as identified in the provider's fire safety risk assessment dated 27 June 2024 and in the findings from the inspection in March 2024, assurances regarding completion of all necessary works and arrangements in place to ensure residents' safety in the event of a fire in the centre were not adequate. An urgent action plan was issued following the inspection in respect of Regulation 28: Fire precautions.
- Fire safety checking procedures and simulated emergency evacuation drills were not effectively identifying deficits in the operation and integrity of fire doors, and that residents' evacuation needs would be met. Consequently, the provider could not be assured regarding residents' safety in the event of a fire in the centre.
- Management systems did not identify potential risks, and the provider did not carry out risk assessments in regards to potential fire risks related to the effectiveness of fire doors.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed a sample of residents' contracts of care. Each contract was signed, and dated and outlined the terms and conditions of the residents' accommodation, including the fees to be paid by each resident.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. Notifications and quarterly reports were submitted as required and within the time-frames specified by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

A centre-specific complaints policy was in place and had been updated in line with recent legislative changes. The complaints policy identified the person responsible for dealing with complaints and included a review officer, as required by the legislation. A summary of the complaints procedure was displayed, and was included in the centre's statement of purpose document.

Procedures were in place to ensure all expressions of dissatisfaction with the service were recorded, investigated and the outcome was communicated to complainants without delay. Agreed actions to address the issues raised were implemented.

Access for residents to advocacy services to assist them with making a complaint was in place and residents were informed about this service.

Residents knew who they could talk to if they had a complaint, and that they could access advocacy services to support them if needed.

Complaints received were reviewed as part of the centre's governance and management process.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had the required Schedule 5 policies in place, which had been updated within the previous three years as required by the regulations. These formed part of the staff training sessions, including staff inductions. However, actions were required to ensure these policies and procedures were consistently implemented by staff.

This finding is repeated from the last inspection.

Judgment: Substantially compliant

Quality and safety

Overall, this inspection found that significant improvements continued to be required to ensure that the service was safe and provided to a satisfactory standard, particularly in the areas of nursing assessments and care plans, medicines management, residents' rights, protection of vulnerable residents and management

of residents' responsive behaviours. There was evidence that the provider had completed a number of actions to ensure residents were protected from risk of fire, not all necessary works were not completed at the time of this inspection and the provider was required to urgently address inspection findings that posed a significant to residents' safety in the event of a fire and to ensure that they would be safely evacuated in the event of a fire.

This inspection found that residents had timely access to medical, health and social care professional expertise.

Although the majority of residents' nursing needs were generally met, significant actions were necessary to ensure residents' needs were comprehensively assessed and their care plan documentation reliably guided staff on the care and supports that should be provided for them. Residents' care plan information was not of an adequate standard to guide staff on the care they must provide for residents in line with their individual preferences. This posed a risk that residents' needs would not be effectively communicated to all staff. Residents' care plan information did not demonstrate adequate consultation with residents regarding their end-of-life care preferences and the social activities they were interested in participating in. As a result, the social activity programme available was limited, and many of the residents were not provided with opportunities to participate in a suitable and meaningful social activity programme. Improvements were found again on this inspection to be necessary to ensure that residents' care plans were completed to allow for monitoring of residents' hydration needs and to maintain their skin integrity. These findings are repeated from the last inspection.

The provider had completed a number of actions to improve the premises since the last inspection, including the installation of two shower facilities. However, additional actions were required to ensure that the environment and residents' furniture were adequately maintained and that the designated centre conformed to all of the matters set out in Schedule 6 of the regulations.

Notwithstanding a number of improvements made by the provider since the last inspection to protect residents from the risk of fire, the inspectors found that actions to address fire doors to ensure effective compartmentation were not completed. This was a fire safety risk identified in the provider's own fire safety risk assessment (FSRA) and on the inspection completed in March 2024, that were not completed by 31 December 2024 as committed to by the provider in their compliance plan from the last inspection. Completion time-lines for these outstanding fire safety works were not available at the time of this inspection. Satisfactory assurances regarding residents' safe evacuation in the event of a fire in the centre were not available. These findings are repeated from the last inspection in November 2024 and are discussed under Regulation 28: Fire precautions.

Inspectors found that the provider had a number of measures in place to protect residents from the risk of infection. However, areas for improvement actions were identified in infection prevention and control oversight, risk management, and

environmental and equipment management. This finding is repeated from the last inspection and is discussed under Regulation 27: Infection control.

Although the inspectors were assured that residents received their medications, actions were necessary by the provider to ensure that medication management and administration of residents' medicines are in line with required standards and Regulation 29: Medicines and Pharmaceutical services.

Inspectors found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their friends and visitors in the centre. Visits were encouraged with precautions to manage and mitigate the risk of infection to residents.

Residents had access to local and national newspapers and radios. While televisions were available in the communal sitting rooms, some residents in the twin bedrooms shared a television and did not have an individual choice of television viewing and listening as they wished.

Although processes were in place to ensure residents were safeguarded from abuse, there was not adequate oversight of the implementation of these processes, which did not ensure they were effective. For example, the inspectors were not assured that the risk posed to residents' safety by other residents' responsive behaviours was adequately mitigated, as not all incidents were recognised as possible safeguarding incidents, and appropriately investigated and managed.

Regulation 11: Visits

There were no restrictions in place on residents' family and friends visiting them, and visitors were observed visiting residents in the centre throughout the day of the inspection. Residents told the inspectors that their visitors were always welcomed and that they were able to meet with them in a private area outside of their bedrooms as they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were provided with adequate storage space for their belongings and could access and maintain control of their personal possessions and clothing. Residents' clothing was laundered on the premises as necessary, and their clothes were returned to them without delay.

Judgment: Compliant

Regulation 17: Premises

Notwithstanding the improvements made since the last inspection, additional actions were required by the registered provider to ensure that the designated centre conformed to all of the matters set out in Schedule 6 of the regulations. This was evidenced by the following findings;

- Emergency call-bell facilities were unreliable. A call-bell in a communal toilet/shower was not functioning. This posed a risk that staff would not be alerted when residents required their assistance or in an emergency.
- A grab rail in the toilet adjacent to the chapel was loose and would not provide adequate and safe support to residents who needed to use it.
- Paint was observed to be damaged and missing on areas of the en-suite door and adjacent wall in a one resident's bedroom.
- The floor covering in one resident's bedroom was damaged.
- Storage areas were not always well-managed; for example, inspectors observed items to be inappropriately stored on the floors in a linen room and a hoist store room.
- The fabric on some residents' chairs, the cushioned back support on a communal toilet and on a number of seats and kneelers in the chapel.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider did not ensure that the environment and equipment were managed in a way that minimised the risk of transmitting a health care-associated infection. Actions were required by the provider to ensure that all residents were protected from the risk of infection. This is evidenced by the following findings;

- Two hand sanitising stations at the entrance to the designated centre were not working on both days of the inspection. This did not promote good hand hygiene practices for those entering or exiting the centre.
- There was a tagging system in place to identify clean equipment ready for use. However, on both days of inspection, inspectors observed equipment, including wheelchairs, a cleaning trolley and a drugs trolley, which were used by staff and had these tags still in place. Therefore, the system in place was not robust to ensure that equipment was indeed clean prior to use.
- Assurances were not available that hoist slings were used on a single resident basis only to mitigate the risk of cross-infection to residents.
- Some surfaces were damaged and worn, which meant they could not be effectively cleaned. These included damaged paint work, damaged flooring,

tears in the fabric covering on a cushioned back support on a communal toilet, residents' chairs and coverings on seating in the chapel. In addition, a sink in the smokers' room was chipped and damaged, and there was visible build-up of grime around the plug hole. These findings did not support effective cleaning procedures.
- Inspectors observed inappropriate storage of items directly on the floors in a storeroom and the linen room. This prevented the flooring in these areas from being effectively cleaned.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. The inspectors were not assured of the likely performance of the majority of door sets and their ability to contain fire, smoke and fumes. For example:

- The inspectors found that cross corridor fire doors, a door between a treatment room, in addition to doors on several residents' bedrooms and the circulating corridors did not close to create a seal due to areas of incomplete intumescent seals and smoke seals. One cross-corridor fire door had an unprotected keyhole in it.
- Oxygen cylinders were not stored safely in two treatment rooms that contained potentially combustible materials. One treatment room had no means of ventilation and there was a significant unprotected gap around the perimeter of the door on this room. The inspectors were not assured that the risk posed to residents' safety had been identified, risk assessed and had been adequately managed.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents are aware of the procedure to be followed in the case of a fire. For example:

- The inspectors were not assured that there were adequate arrangements in place for evacuating residents in the event of a fire in the centre in the largest compartment (Bedrooms 22-31), which provided accommodation for eleven residents. The most recent evacuation drill records did not provide adequate assurances that the residents in this compartment could be evacuated in a timely, safe and effective manner with the current night time staffing levels.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The oversight of medications management in the centre was not sufficiently robust to ensure that residents were protected by safe medicines management practices. This was evidenced by the following findings;

- Nurses were administering medications in a crushed format; however, this was not the format directed by the prescriber.
- Multi-dose liquid medications observed by inspectors did not have a date of opening recorded on them. This meant that these medicines could potentially be used after the manufacturers' assigned period of opening had lapsed.
- There were gaps identified in the temperature check records for the medications fridge.
- Whilst there was a process in place for the return of medications, no records were maintained in respect of the medications returned to the pharmacy.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvements were required in respect of the care planning arrangements for the residents to ensure that their individual needs were adequately assessed, and that sufficiently detailed care plans were developed to effectively guide the care that residents received. Care plans reviewed did not demonstrate that there was a strong person-centred human rights approach to care in the centre and a number of care plans reviewed were out of date and did not reflect the current, individual assessed needs of residents, nor did they include up to date information in relation to how residents' current needs should be met. Therefore, inspectors were not assured that the residents received person-centred safe and quality care, which promoted positive outcomes for residents. This was evidenced by the following findings;

- Residents' needs were not adequately assessed. Although comprehensive assessments were generally completed on admission, assessments were not repeated over time to ensure that changes in residents' needs were identified and captured. For example, a number of residents had needs for support in order to have their social care needs met. However, these residents had not undergone an assessment of their interests or abilities and did not have a care plan in place to guide staff in ensuring these residents received the appropriate support to participate in activities that were meaningful and appropriate to their needs.
- Care plans were not sufficiently detailed to demonstrate that residents were consulted with regarding their care. For example, inspectors reviewed a number of care plans, including end-of-life care plans and restricted movement care plans, and these demonstrated a strong focus on the wishes of family members rather than those of the resident.

- Residents who were assessed and known to be at a high risk of dehydration did not have sufficiently detailed care plans in place to guide staff practice. Although records were being maintained of residents' fluid intake, care plans did not outline the daily recommended fluid intake for each resident.
- Inspectors reviewed a sample of wound care plans and found that wound assessments were not consistently updated each time a wound was dressed.
- Inspectors reviewed a sample of end-of-life care plans and found that these were not sufficiently detailed to guide staff in meeting residents' end-of-life wishes. For example, there was no information about where the resident wished to be at the end of their life.

Judgment: Not compliant

Regulation 6: Health care

Nursing practices in relation to residents' assessment and care documentation and medicines management did not ensure that residents received a high standard of evidence-based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnaimhseachais. The inspectors' findings are discussed further under Regulation 5: Individual Assessment and Care Plan and Regulation 29: Medicines and Pharmaceutical Services. This finding is repeated from the last inspection.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Not all staff had been facilitated to attend training in responding to and managing residents' responsive behaviours. The inspectors found that this training had commenced, and most staff had attended this training following the last inspection. However, 10 staff had not completed this training by the time of this inspection.

The inspectors found further to review of the accident and incident records and of residents' care documentation, that one resident's escalating responsive behaviours were not being adequately managed and posed a risk of harm to other residents. Strategies to de-escalate the behaviours were not effective, and evidence was limited that the strategies used by staff to de-escalate the behaviours were being effectively reviewed.

Restraint policy guidelines. Approximately one-fifth of the residents had full-length restrictive bedrails in place. Use of full-length bedrails was not always consented to by the residents, and there was no evidence available that less restrictive

alternatives were explored. Additionally, there were no indications that the current practices ensured the bedrails were used for a minimum required duration.

Judgment: Not compliant

Regulation 8: Protection

Residents were not adequately protected from the risk of abuse. The inspectors found, further to review of the accident and incident records and residents' care documentation, that one resident's escalating responsive behaviours were not being adequately managed and posed a risk of harm to other residents. This risk was not identified as a safeguarding incident and there was limited evidence of completion of a preliminary assessment, appropriate referral, development of safeguarding plans and investigation. Consequently, not all reasonable measures were taken to prevent re-occurrence to ensure residents were protected from abuse at all times.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had failed to ensure that residents were provided with adequate opportunities to participate in meaningful social activities that met their interests and capacities.

- The inspectors observed again on this inspection that the social activity programme for residents was limited and was available for a small number of residents only. The inspectors found that many of the residents sitting in the sitting rooms and in their bedrooms on the days of the inspection were not supported to participate in meaningful social activities to meet their interests and capabilities. There was a high dependency on television viewing in the two seating areas. However, as the circulating corridor passed through one area and one side of the second area, residents' comfort with viewing the televisions was negatively impacted by the corridor traffic, which was noisy at times. This observation was supported by feedback from a number of residents again on this inspection, who said that they did not participate in any social activities. Documentation available regarding the social activities each resident participated and engaged in to meet their needs was limited. The inspectors found that the types of activities documented were often not meaningful, and there were gaps in the records where no activities were documented for many of the residents for a number of days.

Residents were not supported to exercise choice in their daily routines to ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents. For example; • Residents in a number of twin bedrooms shared one television. The provision of one television for sharing between two residents did not ensure that each resident had a choice of television viewing and listening. These findings are repeated from the last inspection.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant

Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Camillus Nursing Centre OSV-0000098

Inspection ID: MON-0042729

Date of inspection: 11/04/2025

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A full-time, dedicated Activity Coordinator is now in place, whose sole responsibility is the planning, coordination, and delivery of the activity programme. This role is standalone, with no additional duties, ensuring focused attention on enhancing residents' social engagement and wellbeing. • The coordinator plans and delivers meaningful, person-centered activities every day—both one-on-one and in groups. She also coordinates volunteers to support the activity programme, ensuring residents engage in a variety of recreational and therapeutic experiences, of their choice. • Activities are recorded in residents' notes. • Each resident has a person centered Recreational and Social Care plan, outlining choices about which activities they participate in and how they like to spend their time, promoting their independence and autonomy. • She has completed SONAS training and organizes Sonas groups. • Two HCA's assist the Activity coordinator in providing meaningful activities seven days a week, following the planned schedule. • The designated daily Front-of-House staff members' primary responsibility remains focused on delivering Front-of-House services, ensuring the smooth operation of reception and visitor coordination. In addition to these core duties, they actively engage with residents by accompanying them on outdoor walks and offering hand massages and manicures. • In addition to the existing 16:00hrs–22:00hrs shift, which focuses on resident supervision, a second 16:00hrs–22:00hrs shift has now been introduced. The staff member assigned to this role is responsible for ensuring the prompt response to call-bells, carrying out the evening beverage and snack round at 20:00hrs, and completing breakfast menu selections for the following day. ***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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Those involved in providing activities are now clearly aware of their roles and responsibilities. The full-time activity coordinator supervises the HCA's to provide activities.

• Following the team meeting, the Clinical Nurse Managers (CNMs) clearly understand their leadership responsibility to supervise and oversee the daily operational management of the Centre. They ensure that all nursing staff deliver person-centered care in compliance with established policies and procedures

• The nurses are aware of their accountability in the provision of care and supervision of HCA's. After the morning work period, the Nurses check in with the HCA's to ascertain the status of the residents in their care. This includes oral hygiene, skin integrity, fluid and food intake and the general well-being of the residents.

• We have met the Senior Carers and they are aware that they orgainse the daily care for the residents under the direction of the nurses.

• Care Planning Training specifically for documenting Advance Healthcare Directives and personal wishes at end of life is being arranged through an external company.

• The maintenance person is now fully informed of his roles and responsibilities regarding fire safety checks. Daily, weekly, and monthly fire checks are carried out and appropriately documented in the Fire Register. These checks now include:

- Weekly gap assessments using a stainless steel 1–15mm Gauge Aperture Scale Wedge Feeler to ensure compliance with fire door gap specifications.
- Daily inspections to confirm that all fire doors are unobstructed and functioning correctly.

• The maintenance man reports directly to the administrator to ensure oversight and accountability in line with regulatory expectations.

• A professional training agency has been engaged to deliver staff training in the areas of Safeguarding, Responsive Behaviour, and Dementia. This ensures that all staff receive timely and up-to-date education in line with best practice and regulatory requirements. Training sessions are scheduled for 9th and 15th July 2025, with ongoing sessions planned thereafter as needed.

• CPR training was conducted on 30th June 2025 for nursing staff whose certification is due to expire this year, ensuring continued compliance with mandatory training requirements and preparedness for emergency response.

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• We are now in contact with a professional Management Consultancy firm who specialize in all matters relating to Nursing Home management, to ensure higher standards of quality, compliance, and accountability in running the Nursing Centre. We have scheduled a meeting for 29 July 2025, the earliest available date.
• A structured programme encompassing care planning, education, oversight, governance, and quality improvement will be established. They have confirmed by email their commitment to collaborating with us to enhance the Nursing Centre's governance and management systems.

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 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• To ensure that the Nursing Centre Policies and Procedures are embedded into the daily practice of the staff we will:
- Ensure policies are communicated in clear, easily understood language.
- Audit Schedule – Clinical Operation audits to ensure compliance and put Action Plans in place where needed.
- Audit Accident Complaint and Incident logs to ensure compliance
- Include policies & procedures in training sessions
- Spot checks
- Use staff handovers to reiterate policies & procedures
- Discuss issues at the Monthly Management Quality Meeting and put Action Plans into place.

- Analyze the Weekly Collection of Data to identify trends and non-adherences.
- Regularly communicate updates and changes to all staff.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• All call-bells are operational and form part of the ongoing rolling audit schedule.
• The chapel toilet's grab-rail has been replaced to improve safety
• We have decluttered the storage areas and instructed staff to keep items off the floor to make cleaning easier. With suppliers delivering every two weeks, we will control stock levels to prevent over-stocking.
• Fabric chairs/seats/cushioned back that need re-covering are part of a rolling programme with a local upholsterer who has commenced recovering chairs that are suitable to be recovered, this includes the identified seats in the chapel (completed) and as well as the kneelers. Seats not suitable for covering are being discarded.
• The maintenance programme now covers chipped paint and damaged floor coverings. Staff use a live maintenance log to record issues as soon as they are found.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• All hand-sanitizer units are now operational. We have removed two freestanding dispensers as identified and installed a sanitizing station that is now functional in the entrance hall.
• At handovers, staff are reminded to use the green 'Cleaned' tag correctly so that multi-use equipment is cleaned between each user.
• Each resident who requires a hoist for transferring has two designated slings—stored in their room—one for general transfers and one specifically for lavatory use.
• Fabric chairs, seats, and cushioned backs requiring re-covering are included in a planned rolling programme with a local upholsterer. Items suitable for re-covering will be refurbished using fire-compliant materials; those not suitable will be discarded.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Following inspection and identification of defective or missing smoke seals on fire-door assemblies, all affected seals have been replaced using materials specified by a competent fire-door specialist in accordance with the manufacturer's certification. • The Maintenance man has responsibility for fire door checking, twice a week Tuesday and Friday's. This now includes assessing gaps, using a Stainless steel 1-15mm Gauge Aperture Scale Wedge Feeler. • The identified unprotected key-hole in the cross-corridor fire-door has been permanently sealed using a fire-rated seal. • If any fire-door fails to close properly, a risk assessment will be undertaken, the finding recorded in the risk register, and remedial action completed as soon as reasonably practicable. • On the day of inspection, staff moved both oxygen cylinders outdoors for storage in a secure, well-ventilated area. All staff members have been informed of the new location to ensure ongoing safety. • We've ordered a new treatment room door, replacing the ill-fitting one as identified. A competent company will install it. The manufacturer estimates delivery and installation by July 17th 2025. • Following a comprehensive risk assessment, and with the informed consent of residents and the involvement of their families, we reallocated residents between compartments to achieve a more balanced distribution of dependency levels. Specifically, we reduced the overall dependency within the largest compartment (housing eleven residents) by transferring the highest-dependency resident to a smaller compartment accommodating just three individuals, to ensure more efficient and timely evacuations, reflecting the updated resident profiles and compartment arrangements. • During a recent review, we identified that in one twin room, the resident with the highest level of dependency was positioned furthest from the exit. With the informed consent of the residents involved and in consultation with their family, the married couple occupying the room agreed to swap bed positions. This adjustment has improved accessibility and facilitated a safer and more efficient evacuation process. A subsequent evacuation drill confirmed the effectiveness of this change, reducing the evacuation time to 3 minutes and 56 seconds. • Our pre-admission assessment process has been enhanced to include a thorough evaluation of the prospective resident's dependency level in relation to evacuation needs. This assessment now directly informs admission decisions, ensuring that the placement of residents within specific compartments takes into account safe evacuation procedures and the overall dependency profile of each compartment. ***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 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• A dedicated logbook is now in place to record all medications returned to the pharmacy on a daily basis, ensuring accurate tracking and strengthened medication management practices.

• In response to the two identified gaps in the drug fridge temperature check records, all nursing staff have been reminded of the requirement to carry out and document temperature checks daily. Ongoing monitoring and oversight have been implemented to ensure consistent compliance with this protocol.

• The pharmacy now documents, for each individual medication on the resident's drug Kardex, whether it has been prescribed in a crushed or otherwise altered format. This information is clearly indicated alongside each relevant medication, rather than solely at the top of the Kardex as was previously the practice. This change enhances clarity for administering staff and supports safer medication management.

• Each multi-dose medicine bottle is now clearly labelled with the date it was first opened.

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 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:

• A planning meeting was held with the PIC, APIC, and two CNMs to review care planning, including Hydration Care Plans. One CNM will now assist nurses in person-centered care planning. The new schedule gives CNMs more time for supervision, including oversight of care planning.

• The Management Consultancy Firm will also have a role in auditing and educating nurses in person centered care planning.

• Wound assessments and wound care plans are updated each time a wound is dressed, to ensure the treatment stays accurate and up to date.

• Each end-of-life care plan will include all the details needed to honour a resident's wishes, including where they prefer to die if not at St Camillus.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The Management Company we are engaging with will support us to ensure that Nursing Centre policies and procedures are complied with to provide a high-standard of evidence-based care, especially in relation to Medication management and Care Planning.

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 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Resident records will now include:
- Detailed records of responsive behaviours and any associated risks to others;
- Proactive strategies for managing and de-escalating these behaviours, however when these strategies are proving not effective and the behaviours continue and escalates an assessment of whether the centre can continue to meet the resident's needs will be made.
- Timely referrals to Psychiatry of Later Life when needed;
- The Action Plan will include the involvement of the MDT and the residents' family.

• Resident care plans and the Restrictive Practice Register will now:
- Record each resident's participation in assessing the need for bed rails.
- Document any alternative options considered before using bed rails.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
- A comprehensive assessment prior to admission will be performed to identify any history of any responsive behaviours.

- Accidents and Incidents are reviewed daily and prompt and appropriate action will be taken when safeguarding issues are identified.
- Refer promptly to appropriate agencies when safeguarding concerns arise.
- Monitor and review needs regularly to ensure our care remains safe and effective.
- Early consultation with families when safeguarding issues arise.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A meeting has been held with everyone involved in providing activities for the residents, including those responsible for organizing volunteers.
• The Activity Coordinators role was discussed; to coordinate as well as participate in the various activities to ensure that everyone is included and that there will be several different activities going on at the same time; as well as to identify the days of celebration and be prepared for them, such as St. Patrick's Day, Christmas and Mother's Day. To orgainse one to one with groups of similar abilities.
• The Activity Coordinator has successfully completed the SONAS Level 1 training and is now a certified Sonas Programme Licensed Practitioner (SPLP), enabling them to deliver individual and group therapeutic sessions
• Each day, the Activity Coordinator delivers the planned programme of activities, with Healthcare Assistants supporting her throughout the day.
• This initiative, involving volunteers and external entertainers, was fully implemented on 16/06/2025.
• Every person involved in activities documents the activity in the residents' notes.
• The Pink and Green Sitting Areas are no longer used as routine communal spaces. Instead, they have been redesignated as optional, casual seating areas for residents to use at their discretion—whether while passing through or choosing to sit and relax.
• Each resident in a twin-occupancy bedroom will have their own dedicated television - positioned for personal use. This ensures that each person can make their own viewing choices in privacy, respecting individual preferences and dignity. To facilitate this, our electrician has initiated the installation of wiring, and the TVs have been ordered and are in the process of being installed.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	15/07/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	15/07/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	13/06/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	16/07/2025

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	29/07/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	29/07/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	16/07/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting	Not Compliant	Red	17/07/2025

	equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	17/07/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	13/06/2025
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	13/06/2025
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a	Substantially Compliant	Yellow	13/06/2025

	resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	29/07/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	29/07/2025
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	Not Compliant	Orange	29/07/2025

	than 48 hours after that resident's admission to the designated centre concerned.			
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	29/07/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	29/07/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Not Compliant	Orange	15/07/2025

	to their role, to respond to and manage behaviour that is challenging.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	15/07/2025
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.	Not Compliant	Orange	31/07/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	13/06/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/07/2025

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/07/2025