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 Conlon's Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Church Road, Nenagh, Tipperary
Type of inspection:	Unannounced
Date of inspection:	14 January 2025
Centre ID:	OSV-0000666
Fieldwork ID:	MON-0045524

About the designated centre

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

St. Conlon's Community Nursing Unit is a designated centre operated by the Health Service Executive (HSE). It is located centrally in the town of Nenagh in north Tipperary. The centre is single storey and is designed around an enclosed central garden area. The centre can accommodate up to 25 residents. The service provides 24-hour nursing care to both male and female residents. Long-term care, respite and palliative care is provided, mainly to older adults. Bedroom accommodation is provided in 15 single bedrooms and five twin bedrooms. Two of the single bedrooms and the twin rooms have en suite shower facilities. There are two assisted showers, a specialised bath and six toilets for residents occupying 13 single bedrooms. There is a variety of communal day spaces provided including day rooms, dining room, conservatory and quiet room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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
Tuesday 14 January 2025	09:00hrs to 17:00hrs	Mary Veale	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day. Over the course of the inspection, the inspector spoke with residents and staff to gain insight into what it was like to live in St Conlons Community Nursing Unit. The inspector spent time observing the residents' daily life in the centre in order to understand the lived experience of the residents. The inspector spoke in detail with seven residents. A number of residents were living with a cognitive impairment and were unable to fully express their opinions to the inspector. These residents appeared to be content, appropriately dressed and well-groomed. Residents expressed their satisfaction with staff, activities, the quality of the food and attention to personal care.

St Conlons Community Nursing Unit is located in the town of Nenagh, Co. Tipperary. The centre is comprised of a single-storey building. The centre was registered to accommodate 25 residents. The centre was homely and clean, and the atmosphere was calm and relaxed. The building was well lit, warm and adequately ventilated throughout. Residents had access to a dining room, a large sitting room, a small sitting room, a conservatory and a relaxation room. Communal spaces were spacious and comfortable. The sitting room had a fireplace, armchairs, bookshelves, and a large television. The entrance foyer had a rest area with comfortable seating and a piano.

Residents were accommodated in 15 single rooms and five twin rooms. Two single rooms were spacious and had en-suite bathrooms with a wash hand basin, toilet and shower. Twin rooms had ceiling hoists and an en-suite bathroom with a wash hand basin, toilet and shower. 11 single rooms were small and had a wash hand basin. These single rooms could not accommodate manual handling equipment such as hoists. Residents in these 11 single rooms did not have access to a bedside locker beside their bed due to the size of the rooms which has been highlighted in a number of previous inspection reports. This is discussed further in this report under Regulation 9: resident's rights.

Residents' bedrooms were clean, tidy and had space for personal storage. Lockable locker storage space was available for all residents. Many bedrooms were personal to these resident's containing family photographs and personal belongings. Pressure reliving specialist mattresses, cushions and fall-prevention equipment were seen in some of the residents' bedrooms. Residents living in the 11 small single rooms had access to two shower rooms. Some residents living in small single rooms told the inspector that not having access to their own en-suite bathroom was impacting on their privacy and dignity. This is discussed further in this report under Regulation 9: resident's rights.

Residents had access to an enclosed courtyard yard which contained the centre's designated smoking area. The courtyard had recently been refurbished and had level paving, comfortable seating, matures shrubs, a pergola and raised beds. Three

exits were available into the enclosed garden and these were all unlocked and easily accessible.

The centre provided a laundry service for residents. All residents' whom the inspector spoke with on the day of inspection were happy with the laundry service and there were no reports of items of clothing missing.

Residents were very complimentary of the home cooked food and the dining experience in the centre. Residents' stated that the quality of food was excellent. The menus for all meals and snacks were displayed in the dining room. Jugs of water and cordial were available for residents in communal areas and bedrooms. There was a water dispenser available in the large sitting room. The inspector observed the dining experience at dinner time. The dinner time meal was appetising, well presented and the residents were not rushed. The dinner time experience was a social occasion where residents were seen to engage in conversations and enjoying each others company.

The registered provider did not have a person dedicated to activities but a multi-task attendant was assigned to activities daily. Residents were observed taking part in a quiz, bingo and attending Mass in the sitting room. Residents' spoken with said they were very happy with the activities programme provided and told the inspector that the activities suited their social needs. The daily activities programme was displayed on the corridor near the main foyer and in the sitting room. The inspector observed staff and residents having good humoured banter throughout the day and observed staff chatting with residents about their personal interests and family members. The inspector observed many residents walking with their visitors around the corridor areas of the centre. The inspector observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Books, games and magazines were available to residents. Residents confirmed that they had access to Internet services in the centre. Visits and outings were encouraged and practical precautions were in place to manage any associated risks.

Residents' views and opinions were sought through resident meetings and satisfaction surveys and they felt they could approach any member of staff if they had any issue or problem to be solved. Residents stated that the person in charge and all of the staff were very good at communicating changes, particularly relating to their medical and social care needs.

A number of residents told the inspector that they were disappointed that a move to a new building had not occurred in 2025 but were hopeful that they would be moving to a new modern purpose built premises later this year or early 2026.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

Although there were governance and management arrangements in place, which ensured residents received a good quality of care and support, further action was required to strengthen the management structure in the centre. The provider had progressed the compliance plan following the previous inspection in January 2024. Improvements were found in care planning, staff training, records, governance and management, infection control, fire safety, and complaints procedure. On this inspection, the inspector found that actions was required by the registered provider to comply with Regulation 23: governance and management and areas of Regulation 4: policies and procedures, Regulation 5: care planning, Regulation 9: Residents Rights, Regulation 17: Premises and Regulation 34: Complaints procedure. The inspector followed up on all statutory notifications received by the Chief Inspector of Social Services since the previous inspection.

The registered provider is the Health Service Executive (HSE). The centre is registered for 25 beds providing long term care, respite and palliative care. There was a management structure in the centre with identified lines of accountability and responsibility for this service. The person in charge was supported in the centre by a clinical nurse manager (CNM), nurses, care staff, administration and maintenance staff. The person in charge reported to the general manager. A condition had been attached to the registration of the centre to have a person participation in management appointed. A person had not been appointed at the time of inspection. This is discussed further under Regulation 23: Governance and management.

Improvements were found in the documents maintained in staff records since the previous inspection. All records maintained in the centre were in paper format. Records and documentation were well-presented, organised and supported effective care and management systems in the centre. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available for each member of staff.

Improvements were found in training and staff development. There was an ongoing schedule of training in the centre. An extensive suite of mandatory training was available to all staff in the centre and training was mostly up to date. There was a high level of staff attendance at training in areas such as manual handling, safeguarding, and infection prevention and control. Staff with whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safeguarding procedures. Fire safety training was scheduled to take place the week following the inspection.

Improvements were found in the centres systems for auditing and communication. Since the previous inspection monthly staff and management meetings had taken place. Staff were undertaking a daily safety pause handover to discuss resident care and safety. Audits of infection prevention and control, care planning, falls management, restrictive practice and medication management audits had been under taken since the previous inspection. Not withstanding these improvements in audits and meetings in the centre further review was required of the systems in

place to monitor quality and safety in the centre. This is discussed further under Regulation 23: Governance and management.

There was a comprehensive annual review of the quality and safety of care delivered to residents completed for 2023 with an associated quality improvement plan for 2024. The annual review of the quality and safety of care to residents in 2024 was under review.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frames. The inspectors followed up on incidents that were notified since the centre was registered and found these were managed in accordance with the centre's policies.

There was no records of complaints in the centre recorded since 2023. The person in charge confirmed that the resident's had not made any complaints since then. Residents said they were aware they could raise a complaint with any member of staff or the person in charge. There were three different posters types describing the complaints procedure displayed outside the dining room. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. Improvements required to the complaints procedure are discussed under Regulation 34: complaints procedure.

Regulation 15: Staffing

On the inspection day, staffing was found to be sufficient to meet the residents' needs. There were a minimum of two registered nurses in the centre from 8:00 to 23:00 and one registered nurse on duty from 23:00 to 8:00.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safe guarding, managing behaviours that are challenging and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles. Staff were appropriately supervised and supported.

Judgment: Compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to the inspector. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

Although the provider had good oversight of the centre, management systems required review to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c).This was evidenced by:

- The registered provider had failed to submit to the Chief Inspector the information and documentation set out in Schedule 2 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 as amended in relation to any person who participates or will participate in the management of the designated centre by the 31 October 2024. The person participating in management role will ensure that the person in charge is adequately supported by a suitable senior management team and that there is a sufficient and clearly defined management structure in the designated centre.
- The centres audit processes required review. Some audits completed did not have action plans in place to ensure that quality and safety systems in the centre could be effectively monitored.

- The provider was not adhering to the re-writing of care plans as outlined in the evidence based minimum data set documentation tools for use in HSE residential care settings. This was a repeated finding on the previous inspection.
- There was no record of staff appraisals completed in the centre. This was a missed opportunity as a staff appraisal could provide feedback to the employee on their performance, identify any areas of improvement, and ensure that the service provided is sufficiently resourced to ensure the effective delivery of care. This was a repeated finding on the previous inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the office of the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

The centres complaints policy and procedure required revision.

- The information displayed in the centre complaints procedure required review to include clear and easy to read information to allow residents to effectively make a complaint.
- The centres complaints policy was not updated to include the centres nominated persons.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies outlined below required review:

- The policy for risk management was out of date requiring review since April 2024.
- The policies for the ordering, receipt, prescribing, storing and administration of medications to residents; and the handling and disposal of unused or out-of-date medicines was out of date requiring review since March 2024.

Judgment: Substantially compliant

Quality and safety

Residents who could express a view were satisfied with the quality of the care they received and the inspector observed pleasant engagement between staff and residents throughout the inspection. Notwithstanding these positive findings, the inspector found that care planning, resident's rights, and premises did not align fully with the requirements of the regulations.

There was a good standard of care planning in the centre. In a sample of four nursing notes viewed residents' needs were comprehensively assessed prior to admission and by validated risk assessment tools. Care plans were sufficiently detailed to guide staff in the provision of person-centred care and had been updated to reflect changes required in relation to incidents of falls, infections and prevention of pressure sores. There was evidence that the care plans were reviewed by staff. However, further improvements were required to the resident's care plans which is discussed under Regulation 5: individual assessment and care planning.

The centre was bright, clean and tidy. Improvements had been made to the premises since the previous inspection, areas of the centre had been painted and the linen room had been de-cluttered of personal protective equipment (PPE). A schedule of maintenance works was ongoing, ensuring the centre was consistently maintained to a high standard. Bedrooms were personalised and residents had space for their belongings. The inspector observed that the twin rooms now had mobile privacy curtains in place and ample storage for resident's belongings. Grab rails were available in all corridor areas, bathroom, shower rooms and toilets. Residents has access to a call bells in their bedrooms, en-suite rooms, bathroom, shower rooms and toilets. Further improvements were required to the centre premises which is discussed further in this report under Regulation 17: premises.

Improvements were found in infection prevention and control since the previous inspection. The bedpan washer was observed to be out of order on the morning but was fixed and in working order by the evening of the inspection. Staff had completed infection prevention control (IPC) training. There was an IPC policy available for staff which included COVID-19 and multi-drug resistant organism (MDRO) infections. Staff were observed to have good hygiene practices and correct use of PPE. Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Intensive cleaning schedules had been incorporated into the regular weekly cleaning programme in the centre. The centre provided a laundry service for residents. The centre had contracted its bed linen laundry to a private provider. There was evidence that infection prevention control (IPC) was an agenda item on the minutes of the centres staff meetings. IPC audits included, the environment, PPE, and hand hygiene were evident. A number of the nursing staff had undertaking infection prevention control (IPC) link nurse training.

Improvements were found in fire safety since the previous inspection. The provider had effective systems in place for the maintenance of the fire detection, alarm systems, and emergency lighting. There were automated door closures to all compartment doors, and the doors were seen to be in working order. All fire safety equipment service records were up to date and there was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors to ensure the building remained fire safe. Fire training was completed annually by staff and records showed that fire drills took place regularly in the centre with fire drills stimulating the lowest staffing levels on duty. Records were detailed and showed the learning identified to inform future drills. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents and staff spoken

with were familiar with the centres evacuation procedure. There was evidence that fire safety was an agenda item at meetings in the centre. There was fire evacuation maps displayed throughout the centre, in each compartment. On the day of the inspection there were two residents who smoked and detailed smoking risk assessments were available for these residents. A fire apron, fire blanket, and fire retardant ash tray were in place in the centre's smoking area. A fire extinguisher was available close to the entrance of the smoking area. A call bell was not in place in the smoking room but assurances was received that this was installed the day following the inspection.

There was policy in place to inform management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. There was evidence that staff had received training in managing behaviour that is challenging . Residents' had access to psychiatry of later life. There was a clear care plan for the management of resident's responsive behaviour. It was evident that the care plan was being implemented. The use of bed rails as a restrictive device was kept to a minimum. Bed rails risk assessments were completed, and the use of restrictive practice was reviewed regularly. Less restrictive alternatives to bed rails were in use such as low beds. The entrance door to the entrance foyer area was locked. The intention was to provide a secure environment, and not to restrict movement .

There was a rights based approach to care in this centre. Residents' rights, and choices were respected. Residents were actively involved in the organisation of the service. Regular monthly resident committee meetings took place and informal feedback from residents informed the organisation of the service. The centre promoted the residents independence and their rights. The residents had access to SAGE advocacy services. The advocacy service details and activities planners were displayed. Residents has access to newspapers, Internet service, books, televisions, and radio's. Mass took place in the centre each week. A group exercise activity, a music event and Mass took place on the inspection day. A small number of residents expressed their dissatisfaction with the size of their bedrooms and not having access to en-suite facilities. The impact of the residents issues raised are discussed further under Regulation 9: Residents rights.

Regulation 17: Premises

Action was required to come into compliance with the regulation as per Schedule 6 requirements in the following areas:

- Aspects of the premises were not sufficiently maintained internally and some areas of the centre required painting and repair. For example, the inspector observed scuffed doors, chipped paint on walls, wooden skirting and handrails. The interior walls on the corridor leading into the cleaners store and sluice room was heavily marked and required review.

- The ceiling surface outside bedrooms 23 & 24 showed signs of water leakage damage.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was clean and there was adequate cleaning staff employed. Staff were observed to be adhering to good hand hygiene techniques. There were sluicing facility on the premises which were clean and well maintained. There were two cleaning staff on most days. Staff members were knowledgeable about cleaning practices, processes and chemical use. Handwashing facilities were available for staff in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Measures were in place to ensure residents' safety in the event of a fire in the centre and these measures were kept under review. Fire safety management servicing and checking procedures were in place to ensure all fire safety equipment was operational and effective at all times. Daily checks were completed to ensure fire exits were clear of any obstruction that may potentially hinder effective and safe emergency evacuation. Each resident's evacuation needs were assessed and the provider assured themselves that residents' evacuation needs would be met with completion of regular effective emergency evacuation drills. All staff had completed annual fire safety training specific to St Conlons Community Nursing Unit and were provided with opportunities to participate in the evacuation drills.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- Two of the four care plans viewed did not have documented evidence to support if the resident or their care representative were involved in the review of their care in line with the regulations.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The person in charge ensured that staff had up-to-date knowledge, training and skills to care for residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The inspectors reviewed a sample of care plans and saw that person-centred care plans, outlining where evident, triggers and appropriate interventions, to support residents with responsive behaviour. The use of bed rails was monitored by the management team and alternatives to bed rails such as low low beds and crash mats were in use where appropriate. There was evidence of risk assessments when bed rails were in use.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' right to exercise choice was not always upheld by the registered provider. For example;

- Residents in bedrooms 3, 5, 9, 10, 21, 22, 23, 24, 25, 26 and 29 could not access their bedside locker while in bed. This impacted the residents access to personal items and drinks while in bed.

Residents' right to privacy and dignity was not upheld by the registered provider. For example;

- A small number of residents told the inspector that residents who had a cognitive impairment would enter the bathroom while they were using the shared toilets in the centre. This was a breach of the residents privacy and dignity.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Conlon's Community Nursing Unit OSV-0000666

Inspection ID: MON-0045524

Date of inspection: 14/01/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PPIM:

The Registered Provider's senior manager has been in communication with the Deputy Chief Inspector in relation to Schedule 2 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the requirement for a person participating in management role.
With reference to Regulation 4(2)(b) of SI 61/2015, whilst it is mandatory to have a PIC, the Registered Provider is clearly given discretion as to the need to appoint further persons to participate in the management of the designated centre.
As per the Statement of Purpose for St. Conlon's, there is a sufficient and clearly defined governance and management structure in place whereby the person in charge is adequately supported by the senior management team.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with Regulation 23: Governance and management.

Audit process:

The Viclarity audit tool, which has been implemented within the service, was in the process of being reviewed across all CNUs to enhance its accuracy for the units. The new tool was implemented in 2025, and staff members are being encouraged to participate in the online monthly one-hour briefing of the updated tool. Each audit has been assigned to a staff nurse, who will receive notifications via their work email to complete the audit. The QIPS will be generated based on the audit, and the allotted staff nurses will maintain a folder for each audit. The folder will contain the audit report and a detailed action plan which will be over looked by the CNM to ensure that quality and safety systems in the

unit are maintained.
Care Planning:

There is now a policy in place outlining that care plans only need to be re-written on a 6 monthly basis if required. Completed 18/02/2025.

Staff Appraisals:

The Registered Provider has a HR staff appraisal process in situ i.e. "Performance Achievement". The focus of this process is to assist a staff member and their line manager to openly discuss goals and personal learning and development in a structured way over the course of a year. The "Performance Achievement "process allows a staff member to meet with their line manager to discuss the work that they do, supports the staff member to develop in their role and enhance the work of the team. Nurses will utilise the Professional Development Plan Framework as their performance achievement.

The service will undertake to review implementation of Performance Achievement / Professional Development Plan Framework within the CNU and plan a schedule for its roll out within the next 3 months. Date to be completed: 30/05/2025.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
In November 2024, the Registered Provider Representative received communication from the HSE National Complaints Governance and Learning Team that they had sought clarification from the Department of Health in relation to the management of complaints by HSE facilities for Older Persons. The Department of Health has clarified that all complaints in the HSE are managed under Part 9 of the Health Act, 2004 and under SI 652/ 2006 Health Act 2004 (Complaints) Regulations 2006 as well as HSE policy , "Your Service , Your Say". The Department of Health clarified that S.I. 628/2022 does not apply to HSE operated nursing homes.

This CNU manages complaints in accordance with HSE complaint policy. A review of the information displayed within the CNU will be completed to ensure that it is accurate and easy to read for the residents. Date to be completed 28/02/2025.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Risk Management policy – The current policy is under review by the Quality Safety Service Improvement Department. Date to be completed: 31/03/2025

Medication Management policy:

The Medication Management policy has been reviewed and updated.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The delay in moving to the new building has impacted on the scheduling of the maintenance programme for the upkeep of the designated centre.

The ceiling outside of Bedroom 23 and 24 has been painted. A review of the painting requirements has been carried out schedule of paint works will commence. Date to be completed: 30/04/2025.

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:
A Staff Meeting has taken place where it was discussed that there needs to be documented evidence to support if the resident or their care representatives were involved in the review of their care. This has also been discussed at the 3pm Safety Pause. There has also been a Care Plan Audit. Date to be completed 07/03/2025

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Residents who are unable to access their bedside locker while in bed will have their personal items and drinks placed on their bedside table for ease of access.

Residents are encouraged to lock the bathroom doors while they are in use. Staff are aware of the Residents who have cognitive impairment and will redirect them as appropriate. Staff need to reassure the Residents with capacity that this can be unavoidable, but will increased staff vigilance it should reduce the incidents.

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.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	24/02/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	24/02/2025

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Substantially Compliant	Yellow	28/02/2025
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	31/03/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise	Substantially Compliant	Yellow	07/03/2025

	it, after consultation with the resident concerned and where appropriate that resident's family.			
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.	Substantially Compliant	Yellow	24/02/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	24/02/2025