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:	Kylemore House Nursing Home
Name of provider:	Kylemore House Nursing Home
Address of centre:	Sidmonton Road, Bray, Wicklow
Type of inspection:	Unannounced
Date of inspection:	25 January 2024
Centre ID:	OSV-0000055
Fieldwork ID:	MON-0042625

About the designated centre

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

Kylemore House Nursing Home is located in a residential area in Bray. The designated centre is a short distance from the sea front, DART train station, shops and other amenities. Kylemore House nursing home accommodates both female and male residents over the age of 18 years. Residents' accommodation is provided over two floors with 12 single and 13 twin bedrooms. One twin bedroom has full en suite facilities. En suite toilet and wash basin, facilities are provided in 10 single and seven twin bedrooms. A wash basin is provided in two single and five twin bedrooms. Bedrooms on the first floor are accessible by stairs or a stair lift. A variety of communal areas are available to residents on both floors. A dining room, a small dining room, two sitting rooms, a visitors' room and an enclosed courtyard area are provided on the ground floor. A sitting/dining room and balcony area are available on the first floor. The service employs nurses, carers, activity, catering, household, administration and maintenance staff and offers 24-hour nursing care to residents. Kylemore House nursing home caters for residents with long-term, convalescence, respite, palliative and dementia care needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

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 25 January 2024	07:45hrs to 16:30hrs	Helena Budzicz	Lead
Thursday 25 January 2024	07:45hrs to 16:30hrs	Frank Barrett	Support

What residents told us and what inspectors observed

This inspection took place over one day and was unannounced. Kylemore House Nursing Home is a designated centre for older people, registered to provide care to 38 residents. It is situated in the town of Bray, in Co Wicklow. There were 36 residents accommodated in the centre, with one in the hospital on the day of inspection.

The inspectors arrived before 8 am and observed night staff giving a handover to staff members who were working during the day. The inspectors saw many residents being assisted in getting up and having their breakfast prepared and served.

There was a lively atmosphere apparent, with some residents walking independently or being accompanied from their bedrooms to the communal sitting rooms. A staff member was allocated to support the residents in meaningful activities, and the sessions were observed to be lively and inclusive. The residents were singing traditional Irish songs and enjoying the exercises led by the staff.

There were seating areas in the garden on the ground floor, and inspectors observed that the key-pad lock was disabled, and the residents were able to access the garden freely. However, the seating area on the first-floor terrace remained locked with the key-pad. The staff members shared the code for the door with the inspectors as this was not displayed near the key-pad. This arrangement did not ensure that residents had unrestricted access to outdoor spaces.

Residents spoke very positively with regard to the quality of food in the centre. Food was observed to be attractively presented, and there was a sufficient number of staff on duty to assist those who needed additional support. While there was a dedicated dining room facility available, the inspectors observed that the meals were being served to the residents in the sitting room on the ground floor. The staff members unfolded two folding tables and covered them with white cloths before meal times. Three residents were seen sitting around these table settings, and two residents were seated in specialised wheelchairs. Staff members said that these residents need assistance with their mobility needs, and they could not access the dining room as they were not able to use the stair lift. This information was also present in the documentation reviewed by inspectors. Staff also stated that this was the daily routine of how the residents dined. Another six residents stayed in their bedrooms and had their meals served there. Staff members said that four of these residents always received their meals in their bedrooms. Inspectors observed that staff were available to assist the residents with their meals. Five mobile residents residing on the first floor were observed enjoying their meals in the dining room on the ground floor.

The inspectors spoke with the residents, who happily chatted with inspectors about their day, their hobbies and dreams of travelling by plane. They said they were

enjoying the meals, and 'the food was lovely and tasty'. Another resident stated that 'they are used to having dinner in the sitting room, and they enjoyed chatting with other residents'.

Staff members who spoke with the inspectors demonstrated a good knowledge of residents' individual needs and preferences. However, an improvement in recognising and respecting residents' rights to assist residents in a discrete and supportive manner was required, as inspectors observed personal care provided to a resident in a way where a resident was transferred from the assisted bathroom not decently dressed, which did not demonstrate and honour their dignity as discussed under Regulation 9: Residents' rights.

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

This was an unannounced risk inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspection was also conducted to review fire safety precautions in the centre.

Kylemore Nursing Home Limited is the registered provider for Kylemore House Nursing Home. It is a family-owned and operated company comprising of two directors. The inspectors met the new person in charge of the centre, who had been appointed since the previous inspection. The inspectors observed improvement in the staffing levels in respect of the nursing staff. The clinical nurse manager role remained vacant, and the provider representative informed inspectors that they were actively recruiting for this role.

While there were some systems in place to identify and mitigate risk, the inspectors identified other health and safety risks on this inspection in respect of premises, which had not been identified by the provider. As a result, the registered provider did not have mitigating measures in place to minimise or eliminate their impact on the safety of the residents and service provided, which is further discussed under Regulation 17: Premises.

While general non-clinical oversight was provided in the centre by the provider representative and other management personnel, the clinical nursing oversight of the centre was not adequate. The inspectors observed that some of the audits were completed by the staff nurses, and there were efforts in place to manage the clinical aspects of residents' care and identify areas for improvements; however, there were no systems of clinical oversight to ensure that all identified and required actions were completed and reviewed to ensure effective quality improvement for the care of residents. Inspectors also reviewed the electronic nursing system and were given

a list of residents residing in the centre dated 25 January 2024, outlining their names, room numbers, dependencies, and other clinical needs. However, this information was not accurate and did not align with the findings of the inspection, as inspectors observed discrepancies between the information provided on the electronic nursing system and the list of residents' overviews given to the inspectors. This is further discussed under Regulation 5: Individual assessments and care plans and Regulation 6: Health care.

There were two incidents recorded since the previous inspection in December 2023. One of these incidents was an alleged incident of peer-to-peer abuse which had not been notified to the Office of the Chief Inspector. The inspectors requested that the relevant notification would be submitted retrospectively.

Inspectors reviewed the fire safety management systems to protect residents from the risk of fire. The provider had utilised the services of a contractor to provide a Fire Safety Risk Assessment (FSRA) of the centre issued on 29 March 2019. This fire safety risk assessment reviewed the nature and structure of the building. Some of the actions required on foot of this FSRA were not in place in the centre at the time of inspection; for example, storage units were placed under the front stairs, contrary to the FSRA advisory to keep the area "sterile of all storage and of all activities other than circulation".

Daily, weekly and monthly audits of fire safety systems were in place and were up-to-date. However, these audits did not identify issues with fire doors and escape routes. Inspectors found that some containment and gapping issues around fire doors were being addressed; however, there was no sign-off to provide assurance that the fire door integrity was maintained. Inspectors noted the addition of "drop-sills" to bedroom doors with significant gaps underneath. Drop-sills close the gap under the door when closed, but the fixture is required to have a fire rating to match the door design. It was not clear whether these devices matched the fire rating design of the doors they were fitted to.

The procedures for evacuation required urgent review. Residents on the first floor of the front section of the building are required to evacuate vertically in the first phase of evacuation. The procedure posted on the walls at the centre referred to horizontal evacuation and to "Move residents Two compartments away from the site of fire". This was not possible in the front section of the building. This difference in procedure was not reflected in evacuation procedures, and when asked, staff relied on the ability of the residents in this area to evacuate without the use of evacuation aids. This was not reflected in the assessed dependency and ability levels of the residents living in these rooms, as PEEPs (Personal Emergency Evacuation Plans) present in the resident's rooms reflected some residents who "can not open fire escape doors" or "will not be alerted by the fire alarm" if sleeping. This level of assistance was not trialled by staff at the centre.

Due to the fire safety risks found, the provider was issued with an urgent compliance plan in the days following the inspection to ensure that action was taken to mitigate some of the high-level risks. The provider engaged with this process, and the response did assure the Chief Inspector that appropriate action was taken and

that remedial works were instigated immediately following the inspection. Further fire safety findings are detailed under Regulation 28: Fire Precautions.

Regulation 14: Persons in charge

The new person in charge of the centre had the relevant experience and qualifications required for the role.

Judgment: Compliant

Regulation 21: Records

Management of records was not fully in line with regulatory requirements, as follows;

- All records were not kept in accordance with requirements as set out in Schedule 3 for a period of not less than 7 years after the residents ceased to reside in the designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

In consideration of fire safety and premises matters identified during inspection, the inspectors were not assured that appropriate management systems were in place to ensure the service provided was safe, appropriate, consistent and effectively monitored by the provider. For example;

- Daily audits of the means of escape and weekly audits of the fire alarm and fire doors were being carried out. However, these audits were not robust and did not identify concerns relating to the fire rating integrity of fire doors, storage along escape corridors or obstructions to escape routes, which resulted in a lack of assurance that the escape routes would be protected in the event of of a fire.
- Remedial works completed to doors throughout the centre was being carried out by in-house maintenance personnel. No record of auditing of the fire doors by a competent external party was available to ensure that the remedial works were adequately addressing the fire safety concerns, and that the fire doors would perform as expected by their fire rating in the event of a fire. This arrangement was not sufficient to provide assurances that the escape routes were protected in the event of an evacuation.

- An Urgent compliance plan was issued to the provider following the inspection relating to high risk issues identified with:
    - Obstructions on means of escape.
    - Assurances that residents in a section of the older building first floor, were ambulant only, as the route to safety in the event of a fire required residents to travel down the stairs, as there was no compartmentation of the stairwell, which was the only means of escape from this area. There were inconsistencies between the PEEPs for these residents and the staff knowledge of the their mobility.
    - Fire drills to ensure that staff would be able to evacuate residents, and were familiar with the procedure to evacuate residents in all areas of the centre as the procedures differed throughout the centre.
    - A lack of fire and gas detection in a boiler room.

The response to this urgent compliance plan did provide assurance to the Chief Inspector that appropriate action was taken to mitigate these risks.

- The use of some areas of the centre for storage, as well as previous concerns relating to the premises, were not adequately risk-assessed by the provider. For example:
    - The use of external storage areas, which were not weather-tight and used for the storage of cleaning products, etc, presented difficulty in maintaining the items in a clean and usable condition.
    - A section of the floor on the first floor of the older building at the landing was sloping towards the landing at the top of the stairs. While inspectors were assured that this did not present any structural concerns in the centre, it did present a risk to residents, staff and visitors in this section of the building as the floor was not level for walking on or for moving wheeled equipment due to the potential for the wheeled items to move towards the stairs. Furthermore, the handrail at the top of the landing was low, at a height of 810mm. Inspectors were concerned that this railing would not be sufficient to prevent a resident from falling over the railing, if they had to rely on it for balance in this area. These issues are detailed further under Regulation 17: Premises.
    - Furthermore, based on the evidence outlined in this report, the inspectors were not assured that all residents had access to adequate and accessible premises and facilities that met residents' assessed needs, as further detailed under Regulation 17: Premises. In addition, there were insufficient showers and accessible toilet facilities available to the residents located on the ground floor.

The registered provider did not ensure that the designated centre was used at all times in line with its conditions of registration and registered Statement of purpose. Facilities that were registered for residents' use, such as the dining room on the first floor, were converted to the staff room without a prior agreement with the Chief Inspector. As a result, the communal space for residents was reduced. No

application to vary the conditions of registration had been submitted to the Chief Inspector to allow for an impact assessment before making such changes.

Management and oversight systems in place were not effective in maintaining compliance with the Health Act 2007 (Care and Welfare of resident in Designated Centres for Older People) Regulations 2013 and ensuring that residents' care and services were delivered in line with the centre's statement of purpose and that the residents were afforded best-evidenced and safe care. This is further evidenced by:

- A failure of information governance systems, such as errors in some clinical risk assessments and discrepancies between assessments, care plans and a list of residents also used as a staff handover tool, created risks that information shared with other staff members was not accurate, and residents may not receive an appropriate level of care.
- The inspectors were not assured that systems in place to ensure residents were effectively safeguarded at all times were sufficient. There was no evidence to demonstrate effective oversight, including a comprehensive overview of incidents and robust analysis and review to ensure that all necessary actions were taken to prevent re-occurrences of safeguarding incidents as discussed under Regulation 8: Protection.

Judgment: Not compliant

Regulation 31: Notification of incidents

During the inspection, the inspectors identified that one notifiable incident of allegation of abuse had occurred; however, the Office of the Chief Inspector had not been notified. This was a repetitive finding from the previous inspection.

Judgment: Not compliant

Quality and safety

The findings of this inspection showed that staff strived to provide a good quality of life to the residents living in the designated centre. The inspectors acknowledge that there was a new person in charge appointed on the day of the inspection who had not yet had the opportunity to make an impact on the general oversight of the quality of care. Nonetheless, despite the good nature and kind interactions of staff, inspectors were not assured that the centre was operating with a person-centred approach and high-quality care at all times. Clinical oversight of residents' medical and nursing care was not sufficient to ensure the safety and well-being of residents were maintained.

In addition, infrastructural limitations restricted residents' access to essential communal spaces and registered facilities and did not assure the inspectors that the residents were fully afforded their rights and opportunities to maximise their independence and autonomy.

Inspectors followed up on the care plans for a number of residents directly involved in safeguarding incidents and found that an appropriate safeguarding care plan to protect the resident from any form of abuse was not in place. The behavioural supporting care plans were not updated to include identified triggers from recent incidents and any distraction techniques that staff could employ to reduce the risks and support residents' dignity and privacy during episodes of 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).

A review of residents' records showed that residents were not always facilitated with timely access to health care services, which could potentially have an adverse impact on their outcomes. Accurate dependency levels were not maintained to ensure that adequate, effective care was provided in the centre, both individually and collectively. This is further discussed under Regulation 6: Health care.

Inspectors noted that areas of the centre, which had been designated as resident areas, had been converted to staff areas. Part of the centre was a much older period building, and while inspectors noted that rooms in this section had been tastefully decorated with attention to original detail, some of those original features were posing a slip, trip or fall risk to residents, staff or visitors at the centre. The flooring on the first floor at the front of the building sloped towards the stairs landing. Risks associated with this area, such as the use of wheeled equipment, were not adequately assessed. As the floor sloped towards the stairs, wheeled equipment, such as a cleaning trolley observed by inspectors, could roll to the stairs and potentially collide with someone coming up. There was no lift or other means of accessing this area. The stairs were fitted with a chair lift, which further reduced the usable width of the stairs. A handrail on the landing was also at an insufficient height to prevent a fall if a resident was required to use it. These issues are discussed further under Regulation 17: Premises.

The centre was equipped with a category L1 fire detection and alarm system. However, inspectors noted that some rooms of the centre, which opened onto the escape corridor, did not have fire detection fitted. An external gas boiler room, which was also a storage space for food, was not fitted with a fire detector, nor did it have any measures in place to detect and give warning of a gas leak. Emergency lighting directional signage was in place in most spaces throughout the centre; however, a section of the first floor at the front of the building did not have appropriate directional signage for evacuation. This could lead to confusion during evacuation.

Containment of fire and smoke concerns were identified with some fire doors throughout the centre. These issues ranged from non-fire-rated ironmongery to missing smoke seals to damaged doors which may not contain fire and smoke in the

event of a fire. Containment issues were also identified in linen storage areas on the first floor, in the corridor storage, and in the bedroom doors that opened onto the escape corridor. An external escape route was further compromised by a large skip bag, and an assembly point on the ground floor at the rear of the centre was not accessible for evacuation to the rear at ground floor level. Further fire safety issues are discussed under Regulation 28: Fire Precautions.

Regulation 17: Premises

The registered provider did not ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3:

- Inspectors also observed that the sitting room beside the entrance, which is a registered communal space for residents, was not used by any resident during the day. Due to infrastructural limitations, this room was not accessible to all residents. This room was observed to be used by the registered provider on the day of the inspection. This was a repeat finding from the previous inspection.
- Areas required for the running of the designated centre had not been registered. The provider was advised following the inspection in December 2023 to submit a floor plan of the centre displaying all facilities needed to operate the centre. However, on this inspection, inspectors found that the boiler room, three storage sheds where incontinence wear was stored, and a wooden storage shed for residents' equipment and cleaning equipment in the garden area were not included in the floor plans.
- In line with findings from the last inspection in December 2023, inspectors observed that the dining and communal facilities on the ground floor were not accessible to all residents living in the centre.

The registered provider, having regard to the needs of the residents of the designated centre, had not ensured that the premises conformed to all the matters as set out in Schedule 6. For example:

- The premises were not designed to meet the needs of the residents in all areas. For example, the flooring in the Victorian wing first-floor corridor created a ridge at the transition points, especially around bedrooms 22, 23 and 24, which presented a risk of trips and falls to residents living in this area. The landing area was uneven, creating a sloping towards the stairs, particularly outside bedrooms 21 and 25. This also posed increased trip and fall hazards to residents, which had not been mitigated by the Furthermore, the handrail in the Victorian wing landing was 810 mm high, which may not be sufficient to prevent falls for residents using this area. This, combined with the uneven flooring, presented a risk to residents who may use the handrail in this area.

- Storage facilities were not suitable; for example, an area used for cleaning equipment on the terrace on the first floor was a wooden shed. Inspectors saw that there was a large hole in the wall of the shed created from missing wooden parts. In addition, inspectors observed a hoist, weighing scale, and specialised wheelchairs being stored in residents' bedrooms, which is not appropriate. This is a repeat finding from the previous inspection.
- Similar to the findings from the previous inspection, inspectors observed that only one assisted shower/toilet and one another communal toilet. Which was not wheelchair accessible, was available for the use of 14 residents on the ground floor. The records reviewed showed that seven of these residents were assessed as having high and maximum dependency needs. Inspectors observed an incident described under Regulation 9: Rights, where the infrastructural deficits associated with showers and assisted toilets on the ground floor negatively impacted on residents' rights. While some of the bedrooms on the ground floor had en-suite toilet facilities, these were not accessible and suitable for residents with high-dependency needs who required the use of assistive equipment for transfer and/ or the assistance of two care staff members.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire, for example:

- A boiler house to the rear of the centre, which housed a gas boiler, did not have appropriate fire precautions in place. The associated electrical items, including pumps, switches and timers, were in this room along with the electrical circuit breaker sub-board. This room also stored food products and catering items for the kitchen, as well as freezers for food.
- Oxygen cylinders were found in an open section of the escape corridor, which was used as a nurses' station on the first floor. Unsecured Oxygen cylinders present a risk of Oxygen enrichment, which would increase the likelihood of fire in the event of damage to the cylinders.
- Storage in the centre presented a risk of fire, as non-fire-rated cupboards were used to store linen and other items on escape corridors.

The registered provider did not provide adequate means of escape, including emergency lighting, for example:

- The escape route from the first floor of the older section of the centre was a single means of escape vertically using the main stairs, which directly opened into a residents’ bedroom corridor. The stairs had chair lifts installed, which narrowed the effective width of these stair escape routes to 570mm. This meant that evacuation aids could not be used for residents in this section of

the centre. PEEPs on display in one of the rooms in this area detailed a resident requiring evacuation aids if in the room, as they were not mobile. The PEEPs of other residents living in this area also showed that they required assistance to evacuate, not from a mobility point of view but in terms of communication, supervision and their ability to react to the alarm. A review of the mobility of residents in this section of the centre to ensure that they could all be evacuated in the event of a fire in a timely manner was part of the urgent compliance plan sent to the provider after the inspection. The response to this did give assurances that all residents in this area are independently mobile and could, therefore, be evacuated from this area in the event of a fire.

- The fire escape door from the rear of the first floor was in poor condition, and there was damage to the structure of the door. This may impact the ability of the door to be used effectively in the event of a fire.
- There was no emergency lighting directional signage available on exiting rooms 20, 25 and 21 on the first floor of the older part of the centre. One of these rooms opened onto the half landing of the stairs, and other non-exit route doors in this area may cause confusion to residents, staff, or visitors in the event of an evacuation, as this area requires external evacuation in the first phase of a fire event.

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:

- Fire drills were carried out regularly at the centre; however, inspectors could not be assured that vertical evacuation had been trialled on the various escape stairs. Staff who spoke with the inspectors were not knowledgeable of evacuation procedures and what method of evacuation they would use. The evacuation procedures varied through the different parts of the centre, and vertical evacuation would be required in the first phase of evacuation in the older section of the centre. These differences were not detailed in the procedure for evacuation at the centre. While residents in the first floor older section were mobile, they would still require assistance as their PEEPs reflected that some of the residents would not react to the fire alarm if in their room or may not be able to open fire doors on the escape route.
- Fire drills did not record the time taken to evacuate the largest compartment under periods of low staffing numbers. This meant the inspectors could not be assured that staff had practised an evacuation of all areas under low staffing numbers, for example, at night.

The registered provider did not make adequate arrangements for detecting or containing fires. For example:

- While the centre was equipped with a serviced "L1 type" fire detection and alarm system, fire detectors were not in place in some areas of the centre, including:
    - A linen store room on the first floor escape route.

- Bathrooms on escape routes.
- A room which housed a hot water cylinder and was an inner room within a bedroom.
- Storage cupboards on escape corridors.
- External storage rooms, which were on the route to the assembly point.
- A boiler house to the rear of the centre did not have appropriate fire and gas detection fitted. The provision of fire detection in this area was one of the items in the urgent compliance plan issued to the provider after the inspection. The response to this **did** provide assurance that the detection of fire in this area would be rectified in the days after the inspection.

Containment of fire and smoke was compromised in the linen store room on the first floor corridor. The storage cupboard did not appear to be a fire-rated cupboard, which opened directly onto the bedroom escape corridor.

- A linen storage area room beside the first-floor middle stairs did not appear to have adequate containment measures in place around the frame of the door or around an electrical service penetration in the wall. This room was constructed within the escape stairs, and therefore, containment issues in this storage space may compromise the compartmentation arrangements for horizontal evacuation in this area of the centre.
- Containment issues were noted indoors at the centre, for example, large gapping around the perimeter, and underneath doors, non-fire-rated ironmongery. For example:
- There was a lack of assurance in respect of the fire rating of the ironmongery on bedroom doors and compartment doors throughout the centre. This could result in a lack of protection in the escape corridor in the event of a fire and may jeopardise compartmentation arrangements for evacuation. An example of doors reviewed included the day room compartment door between the older and newer sections of the building. There was a hole in the door from the removal of a door closer. The door also had large gapping at the top, which would make containment of fire smoke and fumes deficient.
- The door between bedroom 21 and the inner room water tank room did not have smoke seals fitted.
- The sluice room on the first floor opened directly onto the escape corridor. There was a gap under the door of over 20mm. Inspectors could not be assured of the fire rating of the hinges, the lock or the handle on this door and therefore, the protection of the escape route would be compromised.
- Concealed chain-type door closers were in place throughout the centre. Some of these closers were painted over, and therefore, inspectors could not be assured of the fire rating of these closers.

A review was required by the registered provider to make adequate arrangements for evacuating where necessary in the event of a fire, of all persons in the designated centre and safe placement of residents. For example:

- The secondary escape route from the first-floor main resident area was over a platform to external escape stairs. The route to safety at the assembly point below was blocked by building debris, plants and furniture on the platform. This was cleared to the side on the day of the inspection and the risk removed as part of the urgent compliance plan.
- The general assembly point at the rear of the centre was one of the common assembly points for evacuation of the ground and first floors. It was not possible to reach this assembly point if evacuating from the ground floor using evacuation aids, as there were a number of steps up to a garden area on the path to the assembly point. While there was a route around the centre to reach the assembly point at the front, arrangements set out in the evacuation plans and fire safety information signs posted within the centre directed readers to the general assembly point at the rear.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed two nursing records and found that one of the residents involved in a safeguarding incident did not have an appropriate safeguarding care plan created to navigate staff in the additional supports required to enable safe care and to implement measures in place to protect residents from repetitive incidents.

The inspectors reviewed the nursing records for two residents involved in a safeguarding incident 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). However, the care plans were not updated to reflect the learning and the actions following the incident.

Additionally, where residents' care plans stated to monitor residents' weight monthly, this was not implemented, as evidenced under Regulation 6: Health care.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that one safeguarding incident was not recognised and investigated, and adequate protective measures were not put in place to protect the residents involved in the allegation from further re-occurrences as per the centre's safeguarding policy. This is a repetitive finding from the last inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

On the ground floor, the inspectors observed a resident being transferred in a wheelchair and covered only with towels after the shower. Part of the naked skin at the side and the back of the resident was exposed. The staff member assisting with the transferring of this resident had to pass the day room where residents were sitting, and stopped at the corridor while chatting with three other staff members and one resident. This was not person-centred care and did not support residents' rights to privacy and dignity.

Residents' rights to exercise choice and access all communal and dining areas and showers/ toilet facilities in the centre continue to be impacted, as evidenced under Regulation 17: Premises.

Judgment: Not compliant

Regulation 6: Health care

The registered provider did not ensure that a high standard of evidence-based medical and nursing care was provided for all residents. This is evidenced by the following;

- The inspectors reviewed residents who experienced weight loss based on the weight report generated by the electronic nursing system. Large gaps of up to three months and weight loss of more than 15 % were evident in the monitoring of residents' weights. This led to delays in referrals for dietetic or medical input. While evidence-based assessment tools were in use, they were not appropriately applied. For example, a resident who lost more than 15% of their weight in three months had their MUST (Malnutrition Universal Screening Tool) score calculated as 0, suggesting no risk. The correct calculation should have been a score of 2, which should prompt a weekly weighing of the resident. In addition, this resident's care plan stated that monthly weights should be recorded.
- Inspectors reviewed residents' records on the nursing electronic systems and saw that the validated risk assessment tool to measure the residents' dependency level was not calculated correctly. For example, a resident's dependency index was calculated as 'Medium dependency', where the staff members assessed the resident as being continent and able to walk with the assistance of one person. However, the staff members on duty and residents' overview records stated that the resident is required to be given enemas (laxative), is incontinent and requires the assistance of two staff members to walk. The staff on duty described the resident as bed-bound for most days.

Recommended professional advice from health care professionals was inconsistently followed. This could potentially lead to poor outcomes for residents. For example:

- One resident record was assessed by a physiotherapist in August 2020 as per the electronic nursing system available to inspectors as requiring a sit-to-stand hoist use and specialised reclining comfort chair use. The manual handling assessment for that resident stated that they required the assistance of two staff members and the use of a wheelchair. The dependency assessment stated that the resident was immobile for less than 50 meters. Staff members who spoke with inspectors confirmed that they did not use a hoist and that two people were assisting the resident with their mobility needs to transfer to their specialised wheelchair. However, there was no record on the electronic nursing system available to inspectors on the day of inspection of any follow-up review or assessment by a specialised health care professional to inform staff practice and ensure the resident received safe, high-quality care.

The inspectors saw that there was a need for a comprehensive assessment by a suitably qualified person to determine the capacity of residents to climb the stairs safely. For example:

- There were nine residents accommodated on the first floor Victorian wing. This area is accessible by stairs and a chair lift only. Two of these residents were assessed as having a risk of falls. The floor in the stair landing area was sloped, and the handrails were low, creating an additional risk of falls for residents residing in the Victorian wing.
- There were 13 residents accommodated in the unit on the first floor. This area is also accessible by stairs and a chair lift only. Ten of these residents were assessed at risk of falls. There was no assessment completed for safe stair use by health care professionals. Some of the dependency assessments stated that the residents were unable to walk the stairs, and staff members who spoke with the inspectors confirmed that this was the case. In addition, the landing areas on the stairs on the first floor were not big enough for manoeuvring a hoist and a specialised or travel wheelchair with the assistance of two staff members. Furthermore, there was no storage space for the hoist and other mobility equipment, such as a wheelchair, if required for assisting residents from the stair lift to the wheelchair, to be stored in the landing area beside the Victorian wing. This meant that residents with impaired mobility were not able to access the communal areas on the ground floor in a safe and risk-assessed manner.

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 14: Persons in charge	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Kylemore House Nursing Home OSV-0000055

Inspection ID: MON-0042625

Date of inspection: 25/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • All records are on our electronic system backed up on discs and paperwork returned to Nursing Home	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Specific tasks carried out are as follows to ensure that we are compliant to Regulation 23 they are achievable and measurable. • Daily audits of the means of escape and weekly audits of the fire alarm and fire doors were are carried out. The issue of fire rating integrity of fire doors, storage along escape corridors or obstructions to escape route This is been dealt with under Regulation 28 • The auditing of the fire doors is dealt with under Reg 28. • Compliance plan carried out imediately following the inspection relating to issues identified as listed below : • Yellow Skip bag collections will now be removed from the front of the nursing home to avoid any obstruction at exits. • PEEPS reviewed and correctly displayed for all ambulant residents in the Victorian Section to the front of the Centre. • Fire drills have been carried out to ensure that all staff would be able to evacuate residents, and are familiar with the procedure to evacuate residents in all areas of the centre . Staff are aware that the procedures differ throughout the centre. • Fire and gas detection is now in the boiler room to the rear of the centre. • The external storage areas have been revamped or replaced as needed after the storm	

damage
• A new screen has been ordered to remove the height issue of the landing handrail and will be instrallled when delivered.
• The provider will establish an inventory of all fire doors and sets to again be reviewed and all features will be recorded in a schedule which will be produced by our fire safety consultant.
• The fire safety consultant will be instructed to prepare a report in respect of this issue.

In relation to the number of showers, accessible toilet facilities, dining areas and communal spaces on the ground floor the provider has requested three architects/engineers to provide quotations for undertaking the review and evaluation of the existing facilities and making recommendations as regards the sufficiency of these resources and any additional facilities required. This is set out in a specific format below which is measurable achievable and in a realistic timebound manner.

- Quotations received by 8th March 2024
- Instruction given by Provider at meeting on the 22nd of March 2024
- Report to be completed no later than 19th April 2024.
- Proposals to be submitted to HIQA for approval following review by provider.

The works proposed we now understand are subject to statutory control under Part M of the Building Regulations and thus require an application to be made for a Disabled Access Certificate (DAC)

- DAC application to be prepared and submitted by 17th May
- Tenders for required works to be prepared by 7th June 2024.
- Tender return due date 21st June 2024.
- Earliest approval date for DAC 17th July 2024.
- Commencement notice submitted 18th July 2024
- Works commence 6th August 2024
- Completion as per contractor programme provided with tender. Anticipated completion date 4th October 2024

Mitigation of dates possible, if DAC processed quicker and if contractor programme shorter than anticipated.

• Communal space for residents has been reinstated on the first floor .
• Management systems are in place and are in compliance with the Health Act 2007 (Care and Welfare of resident in Designated Centres for Older People) Regulations 2013 and residents' care and services are delivered in line with the centre's statement of purpose
• Governance systems have been reinstated and modified to ensure the policies and procedures are been carried out.
• PIC and CNM in situ who review all clinical care provided and clinical documentation in order to improve the quality standards in the Centre
• Errors in clinical risk assessments and discrepancies between assessments have been corrected
• Handover sheet has been reviewed . Errors were identified in the the electronic system giving wrong dates . CNM to review on a daily basis

• The PIC has carried out an overview of the incident and robust analysis and review to ensure that all necessary actions have been taken to prevent re-occurrences of allegations of safeguarding incidents
• In relation to safegurading evidence to demonstrate effective oversight will be included in a comprehensive manner on ther resients care pan should there be anonther incident
• The new PIC is fully aware of her responsibility to the Office of The Chief Inspector in relation to notifiable incidents.
• Management oversight systems have been addressed and are in line with the Statement of Purpose
• Cliniical errors have been addressed and there are no discrepancies between care plans and handover tools used by the clincal staff
• The care plans for our residents demonstrate effective measures in order to make every effort to safeguard each resident
• A comprhensie review of all our systems was carried out following the last inspection

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 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Specific tasks carried out are as follows to ensure that we are compliant with Regulation 31 they are achievable and measurable.

• The provider has made the PIC and all clinical staff aware, that we are legally required to notify HIQA within certain time frames about certain incidents, events, or changes within the centre.
• All current notifications have been sent to date
• Staff have been informed that effective incident reporting requires best practices in documentation and communication.
• Any notification must be comprehensive ,consise,specific with standarised language and should provide enough information to ensure that the inspector is clear on the status of the resident, from a health and wellbeing perspective if an incident of abuse has taken place.
• Staff have been informed of our standardised format for incident records, ensuring that they include essential details like date, time, incident description, affected systems, resolution steps, and preventative measures.
• The PIC is fully aware of the impact on the residents of any incident which might occur. All staff are trained to be responsive to residents needs in this situation.
• All key tasks have been discussed with the clinical staff which are notification of the

incident, identification of responsible, interviews, investigation, analysis, and conclusion.
• Sharing and learning discussed at Governance meetings will include the incident, prior controls that were in place, measures taken and the implementation of response, outcomes and timeframe .

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Specific tasks have been carried out as follows to ensure that we are compliant in relation to Regulation 17.

• The room on the first floor has been reconfigured and staff have been reminded that this is residents communal space.
• Floor plans have been sent to The Office of The Chief Inspector to include all areas inside and outside relevant to the center.
• The handrail height on first floor landing in the front of the building will be raised by the installation of a protective screen/barrier placed in front to give a protective height of 1100mm in accordance with Part M of the Building Regulations.
• Storage areas outside have been revamped or removed after the storm damage and Staff have been reminded to use the storage areas provided.

In relation to the premises the provider had requested three architects/engineers to provide quotations for undertaking the review and evaluation of the existing premises and making recommendations as regards ensuring the premises compliance with Regulation 17. This includes alleged infrastructural limitations of the premises and access to all communal and dining facilities in the centre as discussed under other Regulations.

The process is set out in a specific format below which is measurable achievable. and in a realistic timebound manner.

- Quotations received by 8th March 2024
- Instruction given by Provider at meeting on the 22nd of March 2024
- Report to be completed no later than 19th April 2024.
- Proposals to be submitted to HIQA for approval following review by provider.

The works proposed we now understand are subject to statutory control under Part M of the Building Regulations and thus require an application to be made for a Disabled Access Certificate (DAC)

- DAC application to be prepared and submitted by 17th May

- Tenders for required works to be prepared by 7th June 2024.
- Tender return due date 21st June 2024.
- Earliest approval date for DAC 17th July 2024.
- Commencement notice submitted 18th July 2024
- Works commence 6th August 2024
- Completion as per contractor programme provided with tender. Anticipated completion date 4th October 2024

Mitigation of dates possible if DAC processed quicker and if contractor programme shorter than anticipated.

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 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The Provider has set out the following numbering 1-18 to come into compliance with Reg 28 The responses are achievable and timebound.

1. Completed as extinguishers already in place.
2. Completed - the cylinder has been secured by bracket onto a wall.
3. These cupboards have been taken out of use.
4. Completed, PEEPs on display in all of the rooms have been reviewed and updated
5. This door will be repaired where damaged awaiting date from carpenter.
6. A wall mounted illuminated way finder has been placed on the wall at half landing level
7. Following the Inspection two Fire Drills were carried out , and the time taken was recorded to evacuate our residents in all areas day and night. Several practices were carried out by staff on evacuation procedures.
8. Fire drills will be in future undertaken to ratio of 1:3 night: day and dated.
with a varying scenario as regards different stair evacuations. Procedure will be.
clarified by 1st May 2024.

9. Completed as required to linen cupboard at first floor stair and boiler house.
Linen cupboards on first floor rear corridor taken out of use. We will ask our fire safety contractor/company as system designers to undertake a full fire risk assessment in respect of these headings and present the findings in respect of bathrooms, hot press, external detached timber sheds, here referred to as storage rooms.
Detectors if found to be required will be installed.
10. Containment issues with this cupboard have been resolved and a detector fitted to the ceiling.

11. In respect of the issues listed in the report and for ease replicated below and

numbered 12-16

12. The doors and fittings in existence are legacy fire doors and fittings.
All new have and future ones will have CE marking as per the requirements of the Construction Products Regulations with a full register of all products kept in house. All new fire doors and fittings will comply with current standards.

13.

14. We will install smoke seals to the door. There is only one door.

15. The provider has installed a sole plate of 34mm width to close the gap under the door. The provider will establish an inventory of all fire doors and sets to again be reviewed and all features will be recorded in a schedule which will be produced by our fire safety consultant.
The fire safety consultant will be instructed to prepare a report in respect of this issue.
16. These Perco trademarked units are pre-Ce marking requirements and are in legacy doors. The provider will undertake a full assessment in conjunction with a supplier.

17. Yellow bag at the secondary escape was moved on day of inspection as noted in report so that there was no obstruction to the escape route. The bag was removed subsequently from the centre by the waste contractor.

18. The provider has instructed its architect to prepare new drawings showing revised evacuation arrangements from the ground floor rear as follows.
The upper lever rear assembly point is to be designated as the assembly point for first floor evacuees only.
Ground floor evacuees will be directed to turn left at the rear ground floor exit door and assemble in the front car park assembly point. This will remove the external timbers sheds to the rear from being allegedly on the escape route.
Drawings specifying this will be prepared and set out on the evacuation plans and posted fire safety information signs.

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:

Specific tasks have been carried out as follows to ensure that we are compliant in relation to Regulation 5. The following are measurable so that we can monitor the

progress of our residents in a realistic, and timebound manner.

• Safeguarding Care plans have been reviewed and updated to navigate staff in the additional supports required to enable them to implement measures to protect residents from repetitive incidences
• All staff are fully trained and aware of the the six principles of safeguarding
• Areas such as how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment are discussed daily
• Care plans have been updated to reflect the learning and the actions following an analysis of the incident, staff are trained to be proactive in managing residents who present with responsive behaviours.
• All residents weights are monitored monthly and logged and a robust analysis is carried out at our Governance meetings. The clinical team, Management and Catering, are all fully involved and are aware of weight gain or weight loss in our residents. The Dietitian has been to visit a number of residents and her professional advice aligned with our clinical and catering staff.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• Safeguarding policy reviewed and staff have been reminded of the 6 principles of safeguarding.
• There is a safeguarding plan in place for our residents at risk in their care plans which includes details of the specific risks,the likely impact on the resident if the risk/s occurs, the proactive measures that will be taken to mitigate the risk; and the reactive measures to any risk that occurs.
• Nursing Staff have been reminded to record all incidents of minor bruising explained or unexplained and if required notify the Office of the Chief Inspector within the specified time frame.
• The Director of Nursing will prepare a preliminary screening report for the local safeguarding team and they will send report to HIQA within 3 working days.
• Open communication with the resident and family will be maintained throughout the process to address concerns and provide updates.
• Based on the medical assessment, appropriate interventions will be implemented to address any identified health issues contributing to unexplained bruising.
• Preventive measures will be explored and implemented to minimize the risk of future incidents.
• PIC will periodically review incidents of unexplained bruising to identify trends, assess the effectiveness of interventions, and implement any necessary improvements to the policy.
• Staff members will receive training on recognising and reporting unexplained bruising during their orientation and ongoing education sessions.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• All staff have been reminded that we operate from a Person-centered approach with our residents and to use the ponchos provided while transferring our residents from the shower area to their respective rooms.
• In order to assess if residents are enabled to exercise their choice to access dining and communal facilities in the center as described under Regulation 17: Premises, the provider has requested three architects/engineers to provide quotations for undertaking the review and evaluation of the existing premises and making recommendations as regards ensuring the premises compliance with Regulation 17 and 23 including accessing dining and communal facilities in the centre.

This is set out in a specific format below which is measurable achievable and in a realistic timebound manner.

- Quotations received by 8th March 2024
- Instruction given by Provider at meeting on the 22nd of March 2024
- Report to be completed no later than 19th April 2024.
- Proposals to be submitted to HIQA for approval following review by provider.

The works proposed we now understand are subject to statutory control under Part M of the Building Regulations and thus require an application to be made for a Disabled Access Certificate (DAC)

- DAC application to be prepared and submitted by 17th May
- Tenders for required works to be prepared by 7th June 2024.
- Tender return due date 21st June 2024.
- Earliest approval date for DAC 17th July 2024.
- Commencement notice submitted 18th July 2024
- Works commence 6th August 2024
- Completion as per contractor programme provided with tender. Anticipated completion date 4th October 2024

Mitigation of dates possible if DAC processed quicker and if contractor programme shorter than anticipated.

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 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Specific tasks have been carried out as follows to ensure that we are compliant in relation to Regulation 6.

• Clinical errors by Nurses on the electronic systems with regard to the correct calculations of weights for residents have been retified. One Nurse has been assigned the responsibility of reviewing the montly weights on all residents. All weights will be checked for any discrepancies or variations.
• The Nurse in Charge will liase directly with residents GP and refer to the Dietitican if necessary

• All residents noted with weightloss will commence on a food & fluid chart within a minimum of 3 days, the GP will be informed, food will be fortified using cream, butter etc, residents with a MUST score of 1 will be referred to the dietician as routine and will be weighed bi-weekly, residents with a MUST score of 2 will be referred as Urgent and weighed weekly, the nurse will decide if there is a further need for a SALT review and follow any advice given by the dietician and inform GP.

• Clinical errors by Nurses on the electronic system with regard to levels of dependency has been reviewed , calculated correctly. and modified to reflect accuate levels. All Staff have been educated as to the levels of all our residents.
• Professional advice from health care professionals has been sought ie Incontinence Unit , Dietican, Physiotherapist and Psychictric services.
• Review of any assessment by a specialised health care professional is recorded and discussed to inform staff practice and ensure that our residents receive afe, high-quality care.
• Clinical notes have been reviewed and all nine residents accommodated on the first floor Victorian wing can use the stairs. All nine residents are fully ambulant as they were on the day of the Inspection
• All residents on the rear first floor who require the use of the chairlift to access the ground floor have being assessed for safe chair use by a professional
• Hoist is left on this floor at the nurses station in case of emergency.No resident has a need for its use on this floor
• Following the HIQA Inspection all residents in the Victorian Section of the NH were re assessed using the FRASE Assessment Tool, one resident scored as medium risk and all other residents scored low risk, residents Barthel Assessment will be reviewed every 4 months or earlier if there has been a change in the residents condition, any change will be reviewed by the GP and referred to Allied Health Care Professionals if required.

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.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	04/10/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	04/10/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and	Substantially Compliant	Yellow	18/01/2024

	4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	04/10/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	18/01/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	18/01/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including	Not Compliant	Red	02/02/2024

	emergency lighting.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	02/02/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	02/02/2024
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	02/02/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within	Not Compliant	Yellow	31/01/2024

	3 working days of its occurrence.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	29/02/2024
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.	Not Compliant	Orange	19/03/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/01/2024
Regulation 8(3)	The person in charge shall investigate any	Not Compliant	Orange	31/01/2024

	incident or allegation of abuse.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	04/10/2024
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	04/10/2024
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	26/01/2024
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.	Not Compliant	Orange	26/01/2024