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

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| Name of designated centre: | Baltinglass Community Hospital |
| Name of provider: | Health Service Executive |
| Address of centre: | Newtownsaunders, Baltinglass, Wicklow |
| Type of inspection: | Unannounced |
| Date of inspection: | 21 January 2025 |
| Centre ID: | OSV-0000485 |
| Fieldwork ID: | MON-0044149 |

## About the designated centre

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

The centre caters for a maximum of 54 residents and provides care to both male and female residents over 65 years of age. The centre provides 54 residential beds; 11 of these beds (including one respite bed) are specifically dedicated to dementia care and will accept residents under 65 years of age with a diagnosis of dementia. There are two respite beds in total in the centre. Accommodation is divided into three units. Ceidin unit accommodates 25 residents in twin and single bedrooms providing a mix of en suite and communal wheelchair accessible toilet, shower and bathing facilities. There is a large communal lounge and dining room and two smaller seating areas. Primrose unit is a specialist 12 bed unit which provides accommodation for residents with a diagnosis of dementia. The unit comprises seven bedrooms providing single and twin bedroom accommodation, one with en suite and communal toilet and bathroom facilities. There is a communal lounge/dining room which leads out to the enclosed dementia friendly garden area and an additional smaller communal room. Willow unit accommodates 18 residents in single and twin bedrooms with a mix of en suite and communal wheelchair accessible bathrooms and toilets. There is a large communal lounge/dining room a small chapel and smaller seating areas leading out to the garden and gazebo. The centre has recently extended the entrance area to provide a pleasant cafe and meeting area which welcomes residents and their visitors.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 48 |

## 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 21 January 2025 | 08:35hrs to 17:45hrs | Lisa Walsh | Lead |
| Wednesday 22 January 2025 | 08:45hrs to 16:40hrs | Lisa Walsh | Lead |

## What residents told us and what inspectors observed

This unannounced inspection was carried out over two days. The overall feedback from residents was of satisfaction with the specific care provided to them by staff. However, some residents reported not feeling safe and protected from abuse in the centre at all times. On day one, following an introductory meeting with the person in charge and assistant director of nursing, the inspector walked around the centre and spent time observing interactions between staff and residents in different units and spoke with residents, visitors and staff to gain an insight into what it was like living in the centre.

The centre is located just outside of Baltinglass town surrounded by farmland. It is registered to accommodate 54 residents and provides long-term residential care, respite residential care and convalescence care services to adults over 18 years of age. It is divided into three units which are set out across one floor. They are referred to as Ceidin, Primrose and Willow Way. The Primrose unit is a dementia specific unit which can accommodate 10 long-term stay residents and one respite resident. The unit is locked with a keypad and residents require assistance from staff to exit. The Ceidin unit can accommodate 25 long-term stay residents and one respite resident and the Willow Way unit can accommodate 18 long-term stay residents. These units are open to allow residents to move freely throughout the building. There were six vacancies on the days of inspection. The inspector was informed by the registered provider that they had closed to admissions in November 2024 in preparation for premises work to be completed in the coming months throughout the centre.

Overall, the centre was nicely decorated. There was a large day/dining room in both the Ceidin and Willow Way units which hosted a variety of activities on both days of inspection. The day room in the Ceidin unit had a large television placed above an electric fireplace, which opened out onto a secure patio garden. The garden also had a smoking shelter for residents to use; there was also a smoking room available in the Ceidin unit. These were fitted with a call bell and appropriate fire equipment such as a metal ash tray and fire blanket. Within the Willow Way unit there was also an oratory which was decorated to a high standard and accessible to all residents.

In the Primrose unit, communal space consisted of a day room, dining room and family room. The dining room had been redesigned to create a more dementia friendly environment, with brightly coloured serving plates and table cloths to support residents' needs. The day room had a neon coloured fish tank which residents' particularly enjoyed in the night-time. There was also a Tower Taffel Table for the residents to engage with and a large notice board with a pictorial activity schedule displayed. The day room opened out onto a secure garden which had trees, shrubs and garden furniture. Some maintenance work was required in the Primrose unit, the ceiling in some of the corridors and respite room in the Primrose unit was observed to be heavily stained from leaks that had previously and repeatedly occurred, and been repaired. Some of the walls were also damp and

requiring repair. The registered provider had fixed the leaks as they appeared and identified that a more substantial piece of work was required for a permanent repair of the pipe work in this unit.

Residents' bedrooms were personalised and homely. Two long panels of glass were present on all bedrooms doors, in one unit there was an opaque film applied to the glass panels to provide privacy for the residents' residing in the room. However, in the other two units the inspector could see into the residents' bedrooms which impacted their privacy and dignity at times.

In general, residents were complimentary of the staff in the centre and the care they received, with one resident saying staff were "extremely good". However, some residents' expressed their dissatisfaction with delays in receiving chiropody care. The inspector was informed that the last scheduled appointment was cancelled due to adverse weather conditions and a new appointment was scheduled. Overall, visitors spoken with also praised the care residents received and the staff in the centre. Staff were observed to be familiar with the residents' preferred daily routines, care needs and the activities that they enjoyed. However, some residents' and their visitors reported to the inspector that they did not always feel safeguarded in the centre and protected from abuse. For example, some residents and visitors detailed incidents that had occurred in the centre and their concern that these had not been responded to appropriately. They expressed their distress to the inspector that their would be a repeat of similar incidents which may put residents at risk of harm. The inspector also observed safeguarding concerns during the inspection and was not assured that these were responded to appropriately.

There was an activity programme in place with planned activities daily. Large group activities took place in the day rooms in Ceidin and Willow Way. On the first day of the inspection, there was a large group of residents doing exercises and playing indoor golf in the morning. In the afternoon, there was a residents meeting which was very well attended by residents'. On the second day of inspection, residents were painting in the morning and playing bingo in the afternoon.

There was a separate activity schedule in place for residents in the Primrose unit, which was tailored to meet the needs of residents with dementia. There were more individualised activities taking place for the residents like hand massage and table top games. Residents and staff also enjoyed a group picnic with tea and biscuits on one afternoon.

The inspector observed the lunchtime experience for residents in each of the three dining rooms. Residents meals were prepared in the kitchen and then transported in a large hot box to the dining rooms and served. Residents' could choose to eat in their bedroom or the dining room and many of the residents were observed to go the dining rooms in the centre for their meals. Menus were available for residents to choose their meals with two options available to them for lunch. Residents who required assistance at mealtimes were observed to receive this support in a respectful and dignified manner. Residents spoken with were highly complimentary

of the food. One resident spoken with said the "food is so good I'd nearly eat the plate and all".

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

## Capacity and capability

Overall, the inspector found that the management systems in place were not effective in ensuring the quality and safety of care provided to residents was safe and consistent. The inspector identified examples of poor governance and management, poor practices in safeguarding residents and protecting them from abuse and responding to and managing behaviour that is challenging. These are discussed under Regulations; protection, training and staff development, governance and management and managing behaviour that is challenging. Additionally, the systems in place with regard to oversight of notification of incidents, residents rights and infection control required review.

On day two of the inspection in light of significant concerns about the oversight and management systems in place to protect all residents from abuse, the inspector issued an urgent compliance plan with respect to Regulation 8: Protection. The registered providers response to the urgent compliance plan provided the required level of assurances and was accepted.

This was an unannounced inspection to asses compliance with the regulations, and to inform the decision for the provider's application to vary condition 1 and 3 of their registration for Baltinglass Community Hospital. The registered provider has sought to revert a currently registered single bedroom back to a twin occupancy bedroom. The information submitted on the application to vary was incorrect and was under review by the Chief Inspector. On arrival to the centre the inspector was informed that there were additional proposed changes to the centre; this is under review by the registered provider. The inspection was carried out over two days with one inspector. The Health Service Executive (HSE) is the registered provider for Baltinglass Community Hospital.

There was a clearly defined management structure with identified lines of accountability and responsibility. The person in charge is responsible for the centre's day-to-day operations and reports to the general manager for older person services. The general manager reported to the head of service and upwards to the chief officer. The person in charge worked full time in the centre and was supported in their management of the centre by one assistant director of nursing and clinical nurse managers on each unit. They were supported by a team of staff nurses, health care assistants, activities staff, catering, household and portering staff.

The registered provider had audit and monitoring systems in place to oversee the service. However, the audit system was not sufficiently robust in all areas as it had failed to identify key areas for improvement such as protection and notification of incidents.

An annual review had been prepared for 2024 on the quality and safety of care delivered to residents in the centre; however, there was no evidence that this had been prepared in consultation with residents' and their families.

Staff had access to mandatory training and almost all staff had up-to-date mandatory training completed in protection of vulnerable residents, with 99% having completed online training and 87% having completed additional in-person training. Eleven staff did not have up-to-date fire safety. While almost all staff had their mandatory safeguarding training completed, the inspectors observations of staff practice found that additional training and supervision were required. For example, records reviewed showed that numerous safeguarding concerns had been logged as complaints and not identified as a potential safeguarding concern so no action was taken to protect residents. In addition, from the inspectors observations of managing 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 inspector was not assured that all staff had the knowledge and skills to respond to and manage this which also impacted the safeguarding of residents; this will be discussed under Regulation 7: Managing behaviour that is challenging.

## Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

An application to vary condition 1 and 3 of the centre's registration was received by the Chief Inspector. The proposed variation was to increase bed occupancy by one in a single bedroom, changing it to a twin room. However, on review of the application the information submitted was incorrect as the room was already registered as a twin room. In addition, there was no information about the proposed changes the provider wanted to make to condition 3 of the centre's registration.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

This inspection found that further training and supervision were required in safeguarding, managing behaviour that is challenging and fire safety. This was evidenced by:

- Numerous safeguarding concerns which were reported to or observed by staff and management and were not recognised as safeguarding concerns, which

had negatively impacted the care provided to residents. This is further discussed under Regulation 8: Protection.

- An incident which was observed by the inspector during the inspection did not indicate that the training and supervision provided to staff was adequate. The response to this incident demonstrated poor practice and potential negative outcomes for residents.
- While fire safety training was provided, the inspector found that eleven staff were out-of-date with their mandatory fire safety refresher training.

Judgment: Not compliant

## Regulation 21: Records

The registered provider had ensured that all records set out in Schedule 2 were maintained in the designated centre and were available for review on inspection.

Judgment: Compliant

## Regulation 23: Governance and management

During the inspection and in two meetings with the provider in April and June 2024 significant concerns in relation to the protection of all residents from abuse were highlighted. There was a continued failure to implement appropriate measures and robust management systems to ensure the service provided is safe and effectively monitored, and the inspector issued an urgent compliance plan for Regulation 8: Protection.

The oversight and systems in place to recognise and respond to safeguarding concerns were not effective. For example, numerous safeguarding concerns had been recorded as complaints and not recognised as potential safeguarding concerns, which the inspector identified during the inspection. The management systems in place had failed to identify these so no effective safeguarding plans were put in place to protect residents'.

On review of senior management meetings the safeguarding of residents was not discussed, despite significant safeguarding concerns being raised in previous provider meetings, by residents, relatives and staff. In addition, no multi-disciplinary meetings were held between July 2024 and December 2024 to discuss the safeguarding concerns in the centre.

The providers response to the urgent compliance plan provided the required level of assurances and was accepted. However, the provider identified a further 60 incidents which had not been identified as potential safeguarding concerns.

The systems of supervision and the training provided did not provide support to staff to carry out their duties to protect and promote the care and welfare of all residents. This was evidenced by staff poor oversight of safeguarding residents from abuse and staffs ability to manage and respond to responsive behaviour and is detailed under Regulation 16: Training and staff development.

The audit system was not sufficiently robust as it had failed to identify key areas for improvement such as poor infection prevention and control and safeguarding practices.

Numerous statutory notifications of suspected abuse of a resident had not been reported to the Chief Inspector within the prescribed time frames.

An annual review had been prepared for 2024 on the quality and safety of care delivered to residents in the centre; however, there was no evidence that this had been prepared in consultation with residents' and their families.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

From a sample of records reviewed in relation to contracts for the provision of services, they contained the number of residents to reside in the bedroom, the services to be provided and information in relation to fees. However, the inspector found that the terms relating to the bedroom to be provided to the resident was not on each contract as required by regulation.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The inspector was not assured that all notifiable incidents had been recorded in the centre. For example, residents', visitors and staff informed the inspector of incidents that had occurred, however, from the records reviewed these were not recorded.

The person in charge had not notified the Chief Inspector of numerous allegations of safeguarding concerns and a notification of loss of heating, as required.

In addition, from records reviewed by the inspector, some details recorded on the incident record or observed by the inspector did not match the information submitted to the Chief Inspector.

Judgment: Not compliant

## Quality and safety

Overall, the inspector was not assured that the systems in place to oversee the quality and safety of care and services promoted a good quality of life for the residents in which their safety and rights were promoted. Significant sustained action was required by the provider to ensure that residents' received care to meet their assessed needs, particularly in relation to protection, managing behaviour that is challenging and residents' rights. Improvements were also required in relation to infection control and premises.

The inspector was not assured that residents were protected and that all reasonable measures were in place to safeguard residents from abuse. Residents reported safeguarding concerns to the inspector with some saying that they did not feel safe in the centre. This is discussed under Regulation 8: Protection.

The centre had a policy to guide the use of restraint and restrictive practices and maintained a register of restrictive practices in use in the centre. Some behaviour care plans in place were not adequate to guide staff practice. Additional action was required to support residents with responsive behaviours and ensure that the staff working in this centre had the knowledge and experience to support their assessed needs. The inspector also observed poor staff responses to those residents who display responsive behaviour.

Residents had access to a full and varied activity programme with residents reporting how much they enjoyed the activities available to them. Regular residents meetings were held where residents were consulted with about the organisation of the centre. Residents had access to telephones, newspapers, televisions and free Internet services; and there were arrangements in place for residents to access independent advocacy services. In addition to this, there were plans to further develop information available to residents' about advocacy and their rights. Although efforts were made to support residents' rights, action was required to ensure residents' could undertake personal activities in private. Action was also required to ensure that some residents choices did not impact the rights of other residents.

There were areas of communal, outdoor and private spaces for residents to use. While the design and layout of the centre was appropriate to the number and needs of the residents accommodated within the centre, the inspector observed significant damage to parts of the ceiling and walls in the Primrose unit in the centre. Management informed the inspector that there was a plan of work to address these issues. This is discussed under Regulation 17: Premises.

While the centre's interior was generally clean on the inspection day, cleaning resident equipment and storage practices required review to minimise the risk of transmitting a healthcare-associated infection. This will be discussed under Regulation 27.

## Regulation 17: Premises

While the premises were designed and laid out to meet the number and needs of residents in the centre, multiple areas required maintenance and repair to be fully compliant with Schedule 6 requirements. For example, there was significant wear and tear in multiple areas of the Primrose unit, including a residents bedroom which was unoccupied on the days of inspection, with walls and ceilings heavily stained brown and damaged from previous leaking pipes that had been repaired.

Although emergency call facilities were available in each residents' bedroom, these were not always accessible to some residents.

Judgment: Substantially compliant

## Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018). However, some storage practices posing a risk of cross-contamination required review. For example:

- Clean and dirty clinical equipment were stored alongside each other.
- Staff were unclear if the equipment in these store rooms was clean or dirty, as there was no identifiable mechanism to determine this and ensure residents received clean equipment.

Judgment: Substantially compliant

## Regulation 7: Managing behaviour that is challenging

The oversight and management of 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) required improvement. From the inspectors observations and from staff spoken with, staff did not demonstrate up-to-date knowledge and skills, appropriate to their role, to respond to and manage responsive behaviour. For example, the inspector observed an incident during the first day of inspection. The response by staff and management to manage this behaviour was not effective and had a negative impact on several residents.

Residents had behavioural care plans in place. However, assessments in place to guide these care plans did not demonstrate that these were in accordance with up-to-date evidence based best practice. For example, on one assessment the intervention recorded did not give guidance to staff on how to manage or respond to the behaviour. Which meant that the behavioural care plan did not have accurate or clear direction for staff to ensure that responsive behaviour was managed or responded to appropriately to manage the behaviour and ensure that appropriate supports were in place for residents with responsive behaviour. In addition, following an incident observed by the inspector, the inspector was not assured that the residents' behavioural support plans was implemented in practice.

Judgment: Not compliant

## Regulation 8: Protection

An urgent action was issued to the registered provider on the second day of inspection in relation to the protection of residents from abuse. The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse in line with the National Policy and Procedures for Safeguarding Vulnerable Person at Risk of Abuse 2014. This was evidenced by failure to;

- Recognise numerous safeguarding incidents recorded in residents records or recorded as a complaint. This negatively impacted residents as incidents and allegations were not investigated and safeguarding plans were not put in place to protect the residents from abuse.
- Residents reported safeguarding incidents to the inspector, which negatively impacted them, and on a review of records these were not recorded or investigated and no safeguarding plans were put in place.
- Staff members also reported to the inspector that some safeguarding incidents were not recorded.
- Some residents and their relatives reported that they did not feel safe in the centre.
- Where a resident did have a safeguarding plan in place, these did not adequately describe the residents care needs and personal preferences in a detailed and person-centred manner required to guide staff to deliver effective, person-centred care. For example, the same safeguarding template plan was used for several residents.
- While most staff members had access to safeguarding training, the inspector found that not all staff were knowledgeable regarding actions they should take if an allegation, suspicion or concern of abuse was reported to them or if they observed or suspected abuse to have taken place.
- Significant concerns in relation to safeguarding residents from abuse had previously been raised and discussed with the registered provider in meetings which took place in April and June 2024, however, there was a continued

failure to protect residents from abuse and implement robust management systems.

Judgment: Not compliant

## Regulation 9: Residents' rights

The inspector observed that some of the activities enjoyed by a small number of residents impacted the rights of other residents'. For example, turning off lights in communal areas when other residents were reading or doing other activities. This impacted on other residents ability to enjoy and engage with activities and was ongoing concern.

The inspector also identified that residents' privacy was not being fully supported in the centre. Two long glass panels were present on all bedroom doors. Some of the panels had an opaque film applied to the glass panels to provide privacy, however, not all glass panels had this measure in place and so the inspector could see into residents' bedrooms.

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** | |
| Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration | Substantially compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 7: Managing behaviour that is challenging | Not compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Baltinglass Community Hospital OSV-0000485

## Inspection ID: MON-0044149

## Date of inspection: 22/01/2025

**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** |
|---|---|
| Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration | Substantially Compliant |
| Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration:<br>• Revised application to vary condition 1 and 3 centre's registration was resubmited to the Chief Inspector with revised information about the proposed changes the provider wishes to make to the centres to increase bed capacity to suppport proposed phased upgrade works. Complete 19/02/2025 | |
| Regulation 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>• Scheduled refresher training by DSKWW Community Safeguarding team to address outstanding safeguarding training. Noting 87% staff with face to face safeguarding and 99% HSEland safeguarding training completed to date. Completion date 04/05/2025<br><br>• Four additional designated officers to be trained generating a total of 8 designated officers across the nurse management team within the designated centre. Completion date 30/06/2025<br><br>• Incident management training will be delivered face to face by the HSE QPS advisor to the designated centre local management team. Complete 30/01/2025 | |

• Incident reporting training will be provided face to face by the HSE QPS advisor to both clinical and non-clinical staff within the designated centre. Complete 28/02/2025

• Designated centre's person in charge will review the existing staff training tracker log to monitor and maintain the safeguarding training compliance level for the centre. Complete 24/01/25 and ongoing thereafter

• Each of the three units within the designated centre have scheduled daily "safety pause/huddles" where staff are encouraged to raise any incidents or scenarios to collectively generate a solution focused action plan promoting a person centre approach. Completed 24/1/25 and ongoing thereafter

• Safeguarding established as standardise line agenda at scheduled monthly Clinical Nurse Manager (CNMs) meetings to promote a more in-depth discussion on any identified safeguarding issues requiring further detailed planning. Completed 10/3/25 and ongoing thereafter

• Staff performance appraisal reviewed and updated by individual unit managers (CNMs) on a bi-annually basis to review skills and knowledge to develop supports to address identified learning outcomes. Completed 10/3/25 and ongoing thereafter

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|---|---|
| Regulation 23: Governance and management | Not Compliant |

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

• All safeguarding concerns recorded on the behavioural incidents log ABC charts have now been reviewed by HSE Quality Patient Safety (QPS) advisor in consultation with PPIM directing all identified peer to peer incidents to be respectively submitted with relevant notifications to DSKWW Community Safeguarding Team and HIQA. Respective submission will also be made for same on the NIMIS (National Incident Management System). Complete 03/03/2025

• Nurse management team to complete an internal audit system daily to ensure records on ABC Behaviour Log are followed up correctly and the effective proccess are implemented to practice Complete 01/02/2025

• Designated centre's safeguarding processes reviewed as a line item at the CNMII monthly meetings. Complete 10/02/2025 and ongoing review thereafter

• Senior management Multidisciplinary Team (MDT) convened two meetings (23rd January and 25th January, 2025) to review the designated centre's safeguarding and challenging behaviors isssues identified on the day of the unannounced HIQA inspection

22/1/25 to strengthen governance oversight. This included representation from Community Safeguarding Team; Community Social worker, HSE Assisted Decision Making (ADM) Lead. Complete 24/01/2025

• The HSE's National Safeguarding Office's "toolkit for managers on safeguarding" to be utilised by designated centre's CNMII immediately to promote greater awareness amongst all staff of the importance of identifying and timely reporting of notifiable incidents as part of everyday work practices. A key objective is to provide a structured review process for every day examination of safeguarding process. Complete 30/01/2025 and ongoing review thereafter

• Independent review of safeguarding practices within the designated centre utilising the HSE's internal audit tool relating to these practices. This will be completed by two external designated officers to the designated centre. Complete 28/2/25

• Refresher training to be provided to the eleven staff identified on the day of inspection to have out-of-date mandatory fire safety training. Completion date 30/09/2025
• Defined supervisory pathway in the designated centres as outlined in the statement of purpose to ensure staff are appropriately supervised Completed 14/3/25 and ongoing thereafter
o CNMIs employed on each of three units within the designated provides supervision to all the HCAs under their remit.
o CNMII employed on each of three units within the designated centre to provides clinical supervision to all the nursing staff under their remit.
o CNMII and CNMI employed on each of three units within the designated centre supporting learning opportunities as part of their supervisory role. This is monitored and tracked through quarterly performance appraisal engagement and one to one meetings with staff as required.
o CNMIIs are supervised by ADONs who in turn are supervised by the DON in the unit.

• Each of the three individaul units within the designated centre have scheduled daily "safety pause/huddles" where staff to provide a platform to raise any incidents or scenarios to collectively generate a solution focused action plan promoting a person centre approach. Complete 14/3/25 and ongoing thereafter

• Scheduled monthly CNM meetings to provide a forum to promote a more in-depth discussion on any identified issues requiring further detailed planning Complete 14/3/25 and ongoing thereafter

• Staff performance appraisal reviewed and updated by CNMs on a bi-annually basis to review skills and knowledge to develop supports to address identified learning outcomes. Complete 14/3/25 and thereafter

• Designated centre's individual ward managers (CNMs) will review and strengthen operational oversight of audit processes ensuring all identified deficits in particular safeguarding and managing responsive behavior audits are addressed through a time bound QIP allocated to individual ward designated CNMII staff. This process will be supported by a status update report to the Person in Charge to enhance the feedback loop to the incident management for the designated centre. Completion target 30/09/25

• Review and strengthen the individual unit governance oversight of incidents, complaints and safeguarding within the designated centre. This includes a standardize feedback process between the individual unit managers, all relevant staff and senior management team to promote sharing of evidence based practice, timely escalation of risk across the centre - Completion target date 30/09/25

• Quarterly trend analysis and action plan of incidents/complaints/safeguarding logs with findings reported to the monthly Quality and Patient Safety meeting to identify any patterns of risk and quality improvement actions required – Completion target date 30/09/2025

• Designated Centre's 2025 Annual Review process reviewed and updated by the Person in Charge to ensure to reflect residents and their families feedback from quality and safety of care analysis aimed at identifying deficits to inform the improvement plan and actions for the following year - Completion target date 31/01/25

• Review and strengthen the designated centre's existing care planning and service development processes that integrates the resident's "will and preference" in line with Assisted Decision Making (ADM) principles. Completed 28/02/25

• ADM training programme delivered to the designated centre staff to enhance resident and family engagement in line with the regulation. Completed 28/02/25

• Resident engagement to be standard agenda at all designated centre planning meetings i.e. advocacy, individual ward forums and general discussion to ensure the centre comply's with the regulation. Completed by 28/02/25 and ongoing thereafter

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| Regulation 24: Contract for the provision of services | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
• Review all residents contracts for the provision of servcies and where gaps identfied addressed including terms relating to the bedroom as required by regulation. Complete 31/03/2025

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| Regulation 31: Notification of incidents | Not Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Nurse management team to complete an audit of all resident records to ensure any identified gaps are addressed regarding the recording and reporting of all notifiable incidents in the centre. Completion date 30/3/25

• Person in charge to notify the Chief Inspector of any unreported allegations of safeguarding concerns and one notifiable loss of heating incident identified on the day of inspection. Complete 27/02/25

• Notifiable incident trend analysis to be discussed at the monthly designated centre's QSSI meetings which are facilitated by the HSE QSSI advisor. Complete 4/03/2025 and ongoing thereafter

• HSE Quality Patient Safety (QPS) advisor reviewed the designated centre behavioural incidents log (ABC chart) in consultation with PPIM directing all identified notifiable incidents to be respectively submitted with relevant notifications to the HSE Community Safeguarding Team and Chief Inspector. Respective submission will also be completed on the NIMIS (National Incident Management System). Complete 28/2/25

• Designated centre's CNMIIs will develop and implement a standardised feedback loop to ensure learnings are applied following incidents/complaints outcomes are reviewed at individual unit level. Completion target date 30/09/25

• Staff informed at the designated centre's Quality and Patient Safety meetings 27/2/2025 by the Person In Charge (PIC) of the importance of timely reporting of the perceived safeguarding concerns for all stages of the management process to the office of Chief Inspector. Completed 27/2/2024

• A review of notification submissions will be carried out by the PIC on a quarterly basis to review compliance. Findings of these notification audit reports reviewed will be reviewed at the Centre's Quality and Patient Safety monthly meeting. Completed 31/3/2025 and ongoing thereafter

• Nurse management team to complete quarterly trend analysis on individual incidents/complaints management to enhance timely reporting on identified patterns of risk in each of the individual units within the designated centre. Finding to be reported at the Centre's Quality and Patient Safety monthly meetings. Completion target date 1/10/2025

• Incident management a standard line item at the monthly meeting between individual unit managers (CNMII) and designated centre's nurse management team to promote shared learnings and timely notification on incident. Completed 24/1/25

| Regulation 17: Premises | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:
• A timebound project plan generated in consultation with relevant subject experts to address identified infrastructure upgrade works within the centre to ensure compliance with Schedule 6 of the regulatory requirements. Completion date 30/06/2026

• Weekly emergency call bell facilities audit process in place to ensure and maintain access availabiity in each residents' bedroom Complete 14/02/2025 and ongoing review thereafter

| Regulation 27: Infection control | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 27: Infection control:
• Review and strengthen local management oversight for the cleaning and appropriate storage mechanisms for clinical equipment to reduce the risk of cross-contamination. Complete 28/02/2025

• Review and enhance the centre's governance oversight processes for supportng staff ascertain if the equipment in store rooms are clean or dirty to ensure residents access to clean equipment. Complete 28/02/2025

| Regulation 7: Managing behaviour that is challenging | Not Compliant |
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Refresher behaviour managment training to be provided to staff within the centre to ensure appropriate governance oversight and management of residents who display responsive behaviours. Completion date 24/03/2025

• Review all residents' with behaviour care plans to ensure they provide clear direction for staff on how to manage responsive behaviours in line with up-to-date evidence based best practice and applied to practice. Complete 28/02/2025 and ongoing review thereafter
• Care Plan audits in relation to responsive behaviuors to be completed by individual unit managers (CNMII) with a particular focus on applying person-centered action plans to support individual residents to navigate their behaviours. Completion date 31/05/2025.

• Designated centre's bi-monthly mutidiciplinary team meeting to agenda item to include behavioural care plan risk reviews. Completed date 30 /3/25

• Application of a risk assessment for each resident displaying responsive behaviour
a. the provision of 1:1 staff support given to a resident's where there is potential risk of abuse to other residents and staff
b. community safeguarding team notified of any incident where a resident to resident abuse occurs
c. Restraint register updated to reflect the current restrictions in place.
d. Residents with responsive behaviour managed in a consistent manner of applying the most effective engaging approach with the least restrictive nature.
e. Nursing care plans updated every four months to reflect the care pathway aligns with the current restrictive practice policy.

• Further positive behaviour training programme provided to staff to enhance the management of responsive behaviours in people with dementia. Completed 24/03/25

• Delivery of dementia specific training programme to staff includes Foundation in Dementia Care, Leadership in Dementia Care, Responsive Behaviours, Lifestory and Activity in Dementia Care and Communication. Completion date 25/04/25

| Regulation 8: Protection | Not Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection: Designated centre's safeguarding processes and enhancement options reviewed as a line item at the CNMII monthly meetings. Completion date 10/02/2025 and ongoing review thereafter

• Centre's Quality Patient Safety (QPS) advisor reviewed the behavioural incidents log (ABC chart) in consultation with PPIM directing all identified notifiable incidents to be respectively submitted with relevant notifications to the HSE Community Safeguarding Team and Chief Inspector. Respective submission will also be completed on the NIMIS (National Incident Management System). Complete 28/2/25

• Senior management Multidisciplinary Team (MDT) convened two meetings (23rd January and 25th January, 2025) to review the designated centre's safeguarding oversight challenges raised and discussed with the registered provider in meetings which took place in April and June 2024 to strength management oversight of issues raised. This included representation from Community Safeguarding Team; Community Social worker, HSE Assisted Decision Making Lead. Complete date 24/01/2025

• Nurse management team to complete an audit of all resident records to ensure all any identified safeguarding gaps are addressed regarding the recording and reporting of all

notifiable incidents in the centre. Completion date 30/3/25

• Person in charge to notify the Chief Inspector of any unreported allegations of safeguarding concerns and one notifiable loss of heating incident on date of inspection. Complete 28/02/25

• Safeguarding incident trend analysis to be discussed at the monthly designated centre's QSSI meetings which are facilitated by the HSE QSSI advisor. Complete 31/03/2025
• HSE Quality Patient Safety (QPS) advisor reviewed the designated centre behavioural incidents log (ABC chart) in consultation with PPIM directing all identified notifiable incidents to be respectively submitted to the HSE Community Safeguarding Team and Chief Inspector. Respective submission will also be completed on the NIMIS (National Incident Management System). Complete 28/2/25

• The HSE's National Safeguarding Office's "toolkit for managers on safeguarding" to be utilised by designated centre's CNMII immediately to promote greater awareness amongst all staff of the importance of identifying and timely reporting of notifiable incidents as part of everyday work practices. A key objective is to provide a structured review process for every day examination of safeguarding process. Completion date 30/01/2025 and ongoing thereafter

• Designated Centre's PIC to review and enhance governance oversight to promote timely efficient utilisation of the controls assurance tracker introduced in 2024 to monitor timely completion of safeguarding processes in line based on HSE Safeguarding Policy (2014). Complete 24/01/2025

• Independent review of safeguarding practices within the designated centre utilising the HSE's internal audit tool relating to these practices. This will be completed by two external designated officers to the designated centre. Finding and action plan presented at the monthly QPS meeting. Completion date 31/4/25

• A respective audit of existing safeguarding plans for last 12 months with a particular focus on adherence to local safeguarding policy. Completed by 2 designated officers external to the designated centre. Complete 28/2/25

• Community patient advocate service liaise directly with all residents. A key focus of this engagement is to identify any specific safeguarding concerns these individuals may have. Complete 28/1/25

• Review all residents' with safeguarding care plans to ensure they adequately describe individual care needs and personal preferences to guide staff to deliver individaulised person centred care plans in line with up-to-date evidence based best practice. Complete 28/02/2025 and ongoing review thereafter

• Refresher safeguarding training to be provided to staff within the centre to ensure appropriate governance oversight and management of residents who display responsive behaviours. Completion date 24/03/2025

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| Regulation 9: Residents' rights | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Review and strengthen the designated centre's existing care planning and service development processes that integrates the resident's "will and preference" in line with Assisted Decision Making (ADM) principles. Completed 28/02/25

• Introduce 1:1 staff special support for the resident identified to impact on the rights of other residents' utilising familiar designated staff onsite to provide tailored activity support. Subject to review on a monthly basis Completion date 25/02/2025 and ongoing review.

• Community patient advocate service liaise directly with all residents. A key focus of this engagement was to identify specific concerns these individual may have the meeting. Complete 28/1/25

• Dimmer light switches installed in the centre to facilitate the dimming of LED lighting to reduce impact on residents engaging in activities. Completion date 01/06/2025

• Review long glass panels in all bedroom doors to ensure there is a opaque film applied to all panels to ensure privacy for all residents Complete 14/03/2025

## 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 |
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| Registration Regulation 7 (2) | An application under section 52 of the Act must specify the following: (a) the condition to which the application refers and whether the application is for the variation or the removal of the condition or conditions; (b) where the application is for the variation of a condition or conditions, the variation sought and the reason or reasons for the proposed variation; (c) where the application is for the removal of a condition or conditions, the reason or reasons for the proposed removal; (d) changes proposed in relation to the | Substantially Compliant | Yellow | 31/05/2025 |

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| | designated centre as a consequence of the variation or removal of a condition or conditions, including: (i) structural changes to the premises that are used as a designated centre; (ii) additional staff, facilities or equipment; and (iii) changes to the management of the centre that the registered provider believes are required to carry the proposed changes into effect. | | | |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training. | Not Compliant | Orange | 30/06/2025 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 30/09/2025 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Substantially Compliant | Yellow | 30/06/2026 |
| Regulation 23(c) | The registered provider shall ensure that management | Not Compliant | Orange | 30/09/2025 |

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| | systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | | | |
| Regulation 23(e) | The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families. | Not Compliant | Orange | 31/01/2025 |
| Regulation 24(1) | The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre. | Substantially Compliant | Yellow | 31/03/2025 |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections | Substantially Compliant | Yellow | 28/02/2025 |

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| | published by the Authority are implemented by staff. | | | |
| 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 3 working days of its occurrence. | Not Compliant | Orange | 30/09/2025 |
| Regulation 7(1) | The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. | Not Compliant | Orange | 25/04/2025 |
| Regulation 8(1) | The registered provider shall take all reasonable measures to protect residents from abuse. | Not Compliant | Red | 30/03/2025 |
| Regulation 8(3) | The person in charge shall investigate any incident or allegation of abuse. | Not Compliant | Red | 30/03/2025 |
| Regulation 9(3)(a) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with | Substantially Compliant | Yellow | 28/02/2025 |

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| | the rights of other residents. | | | |
| 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 | 14/03/2025 |
| Regulation 9(3)(c)(iv) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to voluntary groups, community resources and events. | Substantially Compliant | Yellow | 28/01/2025 |