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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	14 January 2025
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0045949

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	42

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 14 January 2025	09:30hrs to 18:00hrs	Sean Ryan	Lead
Tuesday 14 January 2025	09:30hrs to 18:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in An Teaghlach Uilinn Nursing Home told inspectors that they received a satisfactory standard of care from a team of staff who were kind to them. Residents told the inspectors that while staff provided them with care and support, care was not always delivered to them at a time of their choosing. Residents also stated that the high quality activities programme that they previously enjoyed was not consistently in place.

Inspectors arrived in the morning to carry out an unannounced inspection. Throughout the day, inspectors spoke with several residents and their families to gain insight into their experience of living in the centre. Inspectors also spent time observing interactions between staff and residents, reviewing the premises, and observing the care delivery.

Inspectors spoke with a number of residents in their bedrooms and in communal areas. Residents told the inspectors that staff supported them to get up from bed at a time of their choosing, but they would often have to wait to get dressed or have their morning wash. Some residents reported inconsistent care in the morning time. Two residents told inspectors that they experienced difficulty in getting the assistance they required from staff. Residents reported that while staff attended to assist them in the morning, residents would have to 'skip a shave or shower' as staff were rushing to attend to other residents. Residents told the inspectors that staff were apologetic when this occurred and, while they endeavoured to return, the care was often delayed.

Inspectors observed that supervision and appropriate allocation of staff was inadequate. While residents were observed to be supervised in the communal day room, there was limited staff allocated to support social engagement throughout the day. Inspectors visited the dayroom periodically during inspection to observe the social well-being of residents, including the activity schedule for the day. Activities such as a quiz, room visits, and daily exercises were scheduled to take place at specific times. However, inspectors observed that those activities did not take place on the day of inspection. One resident told the inspectors that they had attended the dayroom expecting activities to be taking place but then returned to their bedroom as there was 'nothing happening'. Another resident had decided to stay in their room because they were aware that the dedicated activities staff were not on duty which meant the schedule of activities would not take place.

Inspectors observed that the premises was bright, spacious, and warm. The provider had redecorated many areas of the premises including corridors. A number of other areas were prepared for painting, and redecoration of corridors on the first floor was progressing on the day of inspection.

The quality of environmental hygiene had significantly improved since the previous inspection of the centre, and the centre was visibly clean throughout. Housekeeping

staff were observed to clean the centre according to a schedule, and cleaning practices were observed to be consistent to ensure all areas of the centre were cleaned.

Residents told inspectors that they had a choice of meals and drinks available to them every day, and they were complimentary about the quality of food. The dining experience was observed to be a social, relaxed occasion. Meals were served to residents in the main dining room, and were attractively presented. Some residents attended the dining rooms, while others chose to have their meals in their bedrooms. Staff were available to provide discreet assistance and support to residents.

Residents were provided with opportunities to express their feedback about the quality of the service during formal resident forum meetings. There was evidence that residents' feedback was acted upon to improve the service they received in areas such as menu choices.

Visitors were seen coming and going throughout the day. A small number of visitors spoke with the inspectors and expressed their satisfaction with the quality of care their relatives received.

The following sections of this report detail the findings with regard to the capacity and capability of the provider, and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

The findings of this inspection were that the provider had established an organisational structure and systems of management to support their governance and oversight of the quality and safety of the service provided to residents. Inspectors observed improvements in relation to the systems in pace to escalate risks, incidents and complaints to senior management. However, while there were improved systems in place to monitor the quality and safety of the service, these systems were not fully effective, particularly in relation to the management of safeguarding and protecting vulnerable residents from the the risk of abuse. Inspectors also found that the organisation, management and supervision of the staffing resources did not ensure that a consistent and quality service was provided to the residents. Furthermore, this inspection found that significant works had been completed to improve the premises and fire safety systems in the centre.

This unannounced risk inspection was carried out over one day by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).

- follow up on the actions taken by the provider to address significant issues of non-compliance found on the last inspection in July 2024 with regard to the governance and oversight of the service.
- review the actions taken by the provider following monitoring notifications submitted to the Chief Inspector, pertaining to the safeguarding and protection of residents.
- review the provider's progress in complying with a restrictive condition attached to the registration of the centre. The condition pertained to completion of all requisite fire safety works by 31 October 2024.
- review unsolicited information received by the Chief Inspector. The information pertained to concerns regarding the quality of personal care delivered, the supervision of staff, the management of residents with complex care needs, and the safeguarding and protection of residents. Some of this information was found to be substantiated on this inspection.

Knegare Nursing Home Holdings Limited, a company consisting of five directors, is the registered provider of An Teaghlach Uilinn Nursing Home. The registration of this designated centre was renewed in October 2024. Due to ongoing issues of non-compliance, the Chief Inspector registered the centre with a reduced occupancy of 43 beds on the ground floor, and a restrictive condition relating to the completion of ongoing fire safety works by 31 October 2024.

The organisational structure had changed since the previous inspection in July 2024, through the appointment of a new person in charge and a regional manager who was a nominated person participating in the management of the centre. The regional manager was responsible for monitoring clinical and operational aspects of the service, in addition to providing governance and support to the person in charge through their presence in the centre for up to three days per week. Prior to this inspection, the Chief Inspector had been notified of a further change to the person in charge of the centre. This had also resulted in the reinstatement of an assistant director of nursing. A clinical nurse manager also supported the person in charge and assistant director of nursing, clinically and administratively.

The provider had implemented a number of management systems to monitor aspects of the quality of the service. Key clinical indicators with regard to the quality of care provided to residents were collated on a weekly basis. This included the incidence of wounds, adverse incidents, nutritional care, and complaints. This information was reviewed by the senior management personnel to identify deficits in the quality of the service to ensure the appropriate policy, procedure, and care pathways were implemented. For example, where resident weight loss was identified, the nurse management team were required to ensure nutritional monitoring was in place, an appropriate care plan was developed, and referrals for further expert assessment were made within a specified time frame. However, inspectors found that some information collated in this report was not always analysed by senior management to ensure the appropriate action was taken in response to incidents such as unexplained bruising and incidents of challenging behaviour. Consequently, the local policy and procedures were not always

implemented to appropriately investigate or learn from incidents, or inform quality improvement actions to ensure residents were protected from risk.

The system in place to manage risk was not fully effective. Known clinical risks, including responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), were not always identified, managed effectively or reviewed, at times leading to impact on other residents. In addition, there was inadequate documentation of some adverse incidents. This meant that incidents could not be fully investigated or analysed, and no quality improvement action was implemented to ensure that risks would be reduced.

Inspectors reviewed the system of record management in the centre and found that the provider had complied with the requirement to maintain an accurate record of the duty roster worked by staff in the centre. However, inspectors found that some records did not meet the requirements of the regulations. For example, records in relation to staff personnel files and records of care provided to residents were not always maintained in line with professional guidelines, regulatory requirements, or the centre's own policy. In addition, records of adverse incidents were not always appropriately maintained. Consequently, incidents were not documented to include a full investigation or analysis, and no quality improvement actions were documented.

Notifiable incidents, as detailed under Schedule 4 of the regulations, were not always submitted to the Chief Inspector of Social Services within the required time-frame. For example, the Chief Inspector had not been notified of a number of potential safeguarding incidents.

The provider was responsive to the receipt and resolution of complaints. Records of complaints were maintained in line with the requirements of the regulations. A review of the complaints register evidenced that complaints were appropriately managed and were used to inform quality improvement initiatives.

Inspectors found that the organisation and management of staffing resources was ineffective. A review of the staffing rosters evidenced that staffing resources were not always available to cover unplanned leave, particularly in terms of health care staff, and staff to support the provision of social care to residents, and no alternative arrangements were made. Inspectors found that this impacted on the quality of care provided to residents, particularly in relation to their personal care and social care needs.

Staff had access to education and training appropriate to their role and a training schedule was in place. Staff had completed training such as fire safety, safeguarding of vulnerable people, and manual handling techniques.

There were ineffective systems in place to supervise staff to provide safe and effective care to the residents. Staff allocated to provide care to residents did not always deliver care to residents in line with their assessed needs and care plan including their personal care, social care and supervision care needs.

Regulation 15: Staffing

The provider had not ensured that sufficient staff levels were maintained in the centre to meet the assessed needs of the residents, or for the size and layout of the centre. A review of the rosters found that there inadequate staff available to meet the health and social care needs of the residents. This was evidenced by;

- Residents spoken with reported having to wait a long time for care to be delivered. Inspectors observed a number of residents who did not receive personal care in line with their assessed needs and care plan as a result of staffing constraints resulting from unplanned staff leave.
- Residents reported that the allocation of staff to provide social care was not adequate. Rosters reviewed by inspectors evidenced that in the absence of dedicated activities staff, staff who were rostered to provide directed care to residents were also rostered to provide activities to residents in the dayroom. This impacted on the consistent provision of direct care and social care to the residents.

This is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised. This was evidenced by;

- Inadequate supervision of staff allocated to the provision of social care and personal care to residents in the centre.
- Lack of oversight of the residents' clinical documentation, including the records of care provided to residents with complex behavioural support needs and incident records.

This is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, three staff files did not contain a full employment history, together with satisfactory history of any gaps in employment.
- Records of incidents and the investigation of the incidents in which residents may have suffered potential abuse or harm were not documented in line with the centre's own policy, as required by Schedule 3 (4)(j) of the regulations.
- Records of specialist treatment, and nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of safety location checks for residents at high risk of falls and residents who experience complex challenging behaviours were not maintained in line with the residents care plan.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure that staffing resources were organised and managed to ensure person-centred, effective and safe services were provided to residents. This was evidenced by:

- poor allocation and supervision of staff resources meant that residents were not supported to enjoy meaningful social engagement and activity.
- staffing resources were not adequate to ensure safe staffing levels in the event of planned and unplanned leave.

The registered provider did not ensure that management systems were effectively implemented to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- Management systems of oversight had failed to identify that residents did not consistently received personal and social care in line with their assessed needs and care plan.
- Ineffective record management systems did not ensure compliance with the regulations. There was poor oversight of records pertaining to staff personal files, and records of adverse incidents involving residents were not appropriately documented.
- Inconsistent implementation of policies and procedures designed to safeguard and protect residents. This included the identification of potential risks associated with the management of residents' complex care needs, and implementations of interventions to appropriately manage the risk.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre had a complaints procedure that outlined the process for making a complaint and the personnel involved in the management of complaints. A review of the complaints register found that complaints were recorded, acknowledged, investigated and the outcome communicated to the complainant and the satisfaction of the complainant was recorded.

There was evidence that complaints were analysed for areas of quality improvement and the learning was shared with the staff.

Judgment: Compliant

Quality and safety

Overall, the inspectors observed that the interactions between residents and staff were kind and respectful throughout the inspection. However, the care provided was not always person-centred and delivered in line with residents assessed needs and care plan, particularly in relation to their personal and social care needs. This was compounded by poor allocation and supervision of the staff which impacted on residents' rights to exercise choice in relation to their personal care and access to meaning social engagement. In addition, the quality and safety of the care provided to residents was impacted by inadequate oversight and implementation of the management systems and policies in place to safeguard and protect residents. Inspectors acknowledge that significant action had been taken by the registered provider in respect of premises and fire safety which positively impacted residents' quality of life.

The procedure to safeguard residents was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents should a safeguarding concern arise. However, inspectors found that appropriate action had not been taken to investigate all incidents or allegations of abuse, in line with the centre's own policy. Although staff had completed the mandatory training in safeguarding vulnerable adults, the inspectors found knowledge deficits and that staff did not consistently implement the principles of training into practice.

Inspectors reviewed a sample of resident's assessments and care plans and found significant improvement in this area. Residents' needs were being assessed using validated assessment tools to identify potential risks to residents such as impaired skin integrity and malnutrition. Care plans were underpinned by these assessments and were person-centered. For example, resident's nutritional care needs were appropriately assessed to inform nutritional care plans. These care plans detailed

residents dietary requirements, the frequency of monitoring of residents weights, and the level of assistance each resident required during meal-times.However, this inspection found that residents care and social needs were not always being met, in line with their care plans.

Arrangements were in place for residents to access the expertise of health and social care professionals such as dietetic services, speech and language, physiotherapy and occupational therapy through a system of referral. Residents were provided with appropriate access to medical and health care services.

A review of fire precautions in the centre found that records with regard to the maintenance and testing of the fire alarm system, emergency lighting and fire-fighting equipment were maintained and available for review. A summary of residents Personal Emergency Evacuation Plans (PEEP) were in place for staff to access in a timely manner in the event of a fire emergency. Staff demonstrated an appropriate awareness of the evacuation procedure and an awareness of the actions in place to mitigate the risk fire to residents. The provider confirmed that all outstanding actions in relation to the containment and management of fire had been completed. The provider was awaiting an assessment and sign-off of the completed fire safety works by a competent person to ensure the remedial works were completed to the required standard.

Action had been taken with regard to the maintenance of the premises since the previous inspection. Significant renovations works had been carried out in most areas of the premises. All corridors, communal facilities, and bedrooms were appropriately decorated and maintained. All areas of the premises were accessible to the residents, with the exception of the first floor where a programme of redecoration was nearing completion.

There were opportunities for residents to consult with management and staff on how the centre was organised. Minutes of residents' meetings were reviewed and evidenced that feedback provided by residents was acted upon to improve the service for residents.

While there was an activity schedule in place, residents were not always provided with activities in accordance with the activity on display, or their interests. A review of activity records showed that in the absence of the dedicated activities staff described in the centre's statement of purpose, activities to promote social engagement were not consistently occurring. In addition, residents felt that access to a shower and assistance with personal care needs were restricted to times when staff were available and not always at a time of their choosing.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were not restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of the residents assessments and care plans found that the registered provider did not ensure the assessed needs of residents were consistently met, in line with their individual care plans. For example;

- Residents assessed as requiring assistance with showering, shaving and nail care did not receive this assistance or support in line with their care plan.
- Activities were not delivered to residents in line with their individual care plans.
- Residents with complex behavioural support needs did not receive supervision in line with their assessed needs and care plan.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP) of their choice.

Residents also had access to a range of health and social care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life, and palliative care.

Records evidenced that the recommendations of health and social care professionals were implemented and reviewed to ensure best outcomes for residents.

Judgment: Compliant

Regulation 8: Protection

The registered provider had not taken all reasonable measures to protect residents from abuse, and to provide for appropriate and effective safeguards to prevent abuse. For example;

- Policies and supporting procedures were not consistently implemented, particularly in relation to the detection, prevention and response to allegations of abuse.
- Concerns and allegations were not always investigated in an effective manner in line with regulatory requirements or the centre's own policy and procedure.
- Actions to protect residents from the risk of abuse were not completed. This included supervision of vulnerable residents, and the provision of refresher training to staff with regard to recognising and responding to allegations of abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider failed to provide the residents with opportunities to participate in activities in accordance with their interests and abilities.

Residents were restricted in relation to exercising choice, such as where and how they spend their day, as a result of inadequate staffing levels to provide supervision and support. Personal care, such as nail care, assistance with shaving, and shower times were restricted to times when staff could be available, and not at a time of the residents choosing.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0045949

Date of inspection: 14/01/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. The Person in Charge and the Regional Manager have conducted a comprehensive review of unplanned staff leave and implemented a contingency plan to address unexpected absences. This includes the introduction of an on-call system and the establishment of a dedicated pool of relief staff to ensure continuous staffing levels.
2. To enhance efficiency and care delivery, additional training has been provided to staff on effective time management and the prioritization of residents' care needs.
3. A revised, structured handover process is now conducted for all team members before the commencement of morning care. Additionally, a member of the management team has been assigned to provide supernumerary support and supervision each morning to ensure that residents receive care in accordance with their assessed needs and care plans.
4. Following morning care, daily management meetings are held to discuss any issues or concerns encountered.
5. To maintain high standards of care, monthly audits of staffing levels and care delivery will be conducted to ensure compliance with regulatory requirements. Regular care plan reviews are further scheduled.
6. A structured resident feedback mechanism has been enhanced through regular resident meetings and suggestion boxes, enabling continuous monitoring of satisfaction with care delivery.
7. To ensure the effective delivery of both social care, identified Healthcare Assistants with the capability to facilitate meaningful resident activities are now alternately rostered to ensure the consistent provision of social engagement, particularly in the absence of the Activities Therapist.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. A senior staff member is now assigned to provide direct supervision of staff delivering personal and social care, including evening shifts to ensure management oversight at all times.
2. A daily supervision system has also been introduced, where management conducts regular checks/safety pauses on staff performance, resident interactions, and compliance with care plans. This is an opportunity to discuss any outstanding tasks and the action to complete them.
3. The Regional Manager has implemented a mentorship program to support staff in delivering safe and effective care. Additional training and guidance are provided as required to ensure best practices are upheld.
4. To improve the management of responsive behaviours, the Person in Charge will provide in-house training for all staff. This will include using ABC charts to track behavioural triggers and identify effective interventions.
5. A designated team member is responsible for monitoring incident trends, identifying risks, and implementing corrective actions where needed. This is discussed and reviewed on the weekly Senior Clinical Meeting.
6. A weekly review of care documentation has been added to the Senior Management Clinical Meeting Agenda to maintain oversight and drive improvement.
7. To support real-time record-keeping, monitors have been installed in all corridors, allowing care staff to log records immediately at the point of care.
8. Monthly compliance audits will continue to monitor staff supervision and documentation standards, with findings reported to senior management to ensure ongoing improvement and regulatory compliance.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. A comprehensive audit of all staff personnel files has commenced to ensure full compliance with Schedule 2 of the regulations.
2. Identified gaps in employment history are being addressed, with all missing documentation—including verification of employment gaps are being requested and updated. This process is expected to be completed by March 14th.
3. To strengthen record management, a compliance tracking system has been implemented at the local level by the newly appointed administrator, ensuring that all new staff files are complete before employment begins and remain compliant thereafter.
4. In addition, the HR Department will conduct monthly audits of staff personnel files to maintain ongoing compliance.
5. A review of the centre's incident recording and investigation process has been completed by the Regional Manager to ensure all potential abuse or harm-related

incidents are documented in line with Schedule 3(4)(j) and the centre's own policy.
6. Refresher training has been provided to all staff on the correct procedure for reporting, documenting, and investigating incidents, ensuring accurate and transparent records are maintained.
7. All incidents are reviewed on a weekly basis by the Person in Charge and Regional Manager to ensure timely oversight, compliance with regulatory requirements, and appropriate follow-up actions.
8. This process is further tracked through the monthly KPIs to identify trends, risk factors, and areas requiring improvement, allowing for proactive intervention and continuous quality enhancement in line with HIQA standards.
9. A full review of nursing and specialist treatment records has been completed to ensure compliance with Schedule 3(4)(b) of the regulations.
10. Safety location checks for residents at high risk of falls are now being recorded consistently in line with individual care plans - previous paper records have been replaced with wall-mounted tablets in each corridor, ensuring timely recording of information and checks.
11. All nursing staff will receive refresher training on accurate nursing documentation, including the completion of ABC Charts for residents with complex challenging behaviours. This will ensure that all care provided is appropriately recorded and aligns with regulatory standards. This will be completed by March 30th.
12. To strengthen oversight, daily monitoring of documentation accuracy and completeness has been introduced, with a nominated manager responsible for ensuring compliance.
13. Additionally, monthly audits of nursing documentation will be conducted by the Management Team to ensure continued compliance with regulations.
14. Findings from audits and monitoring will be discussed in RGN and Head of Department meetings. Any areas of non-compliance will be immediately addressed, with corrective actions implemented to maintain high standards of resident care and record management.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Under Regulation 9 – Residents' Rights, measures have been introduced to enhance resident autonomy and meaningful engagement, including dedicated staff oversight of engagement programs and a meeting with senior management on February 26th to improve the social activity calendar.
2. To address Regulation 15 – Staffing, a contingency plan has been implemented to mitigate unplanned leave, incorporating an on-call system and a dedicated relief staff pool.
3. Additional staff training on time management and care prioritization has been provided, and a revised handover process ensures effective communication of residents'

needs, with supernumerary management support each morning.
4. Under Regulation 5 – Individual Assessments and Care Plans, daily management meetings following morning care have been introduced to identify and address concerns, ensuring care is delivered in line with residents' assessed needs and documented care plans.
5. To strengthen record management, as outlined under Regulation 21 – Records, a compliance tracking system has been introduced to ensure all staff files are complete before employment and remain compliant. Monthly audits of personnel files will be conducted by the HR Department.
6. Additionally, a review of incident recording and investigation processes has been completed to ensure all incidents related to potential abuse or harm are documented as required under Schedule 3(4)(j).
7. In line with Regulation 8 – Protection, the centre's Safeguarding Policy has been revised and reinforced, with a designated person for safeguarding (PIC) appointed to oversee policy adherence. A clear reporting and escalation process is in place, ensuring that all safeguarding concerns are reported to the Regulator, with a Safeguarding Preliminary Form submitted to the Safeguarding Team for further review.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1. Regular care plan reviews are scheduled monthly to ensure they remain current, person-centred, and reflective of each resident's evolving needs, or sooner if required.
2. A systematic daily monitoring process has been introduced to verify that care interventions are delivered in line with documented care plans. To strengthen oversight, a member of the management team has been assigned each morning to ensure residents receive assistance with showering, shaving, and nail care as required. All care provided will be monitored and documented immediately at the point of care using the newly installed monitors.
3. Residents' individual activity care plans have undergone a full review, and a structured activities schedule is currently under evaluation to ensure that activities are delivered in line with assessed needs.
4. Dedicated staff have been assigned to oversee and facilitate engagement programs, ensuring that residents receive appropriate social stimulation.
5. Additionally, regular resident feedback sessions are now in place to assess activity preferences and participation levels, ensuring that engagement is meaningful and person-centred.
6. Residents have also been invited to join and actively participate in the newly implemented Residents' Social Engagement Committee.
7. To support residents with complex behavioural support needs, all staff will undergo refresher training in responsive behaviour management, focusing on de-escalation techniques and proactive intervention strategies.

8. Daily oversight by the Person in Charge has been implemented to ensure that behavioural support plans are followed, with all interventions documented in line with best practice guidelines.
9. To maintain continuous compliance with HIQA standards, monthly audits of care delivery, activities provision, and behavioural support interventions will be conducted. Findings from these audits will be discussed during weekly and monthly management meetings, with immediate corrective actions implemented where necessary to ensure high standards of care and regulatory compliance.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The centre's Safeguarding Policy and supporting procedures related to the detection, prevention, and response to allegations of abuse have been revised and reinforced with all staff by the Person in Charge (PIC).
2. To ensure consistent implementation, a designated person for safeguarding (PIC) has been appointed to oversee adherence to these policies and procedures.
3. A clear reporting and escalation process has been established to ensure that all allegations are appropriately documented, investigated, and reported to the relevant authorities. In addition to notifying the Regulator, a Safeguarding Preliminary Form is submitted to the Safeguarding Team for further review.
4. To strengthen safeguarding documentation, a dedicated Safeguarding Module has been integrated into the centre's Clinical Management System, ensuring that all investigations and related information are fully recorded in line with policy.
5. Outcomes of all investigations will be reviewed during weekly management meetings, and any necessary corrective actions will be immediately implemented.
6. Safeguarding protocols and best practices will be regularly reinforced during staff meetings to ensure ongoing awareness, accountability, and compliance among all team members.
7. Daily oversight and frequent walkabouts by management have been implemented to provide direct supervision, observe resident-staff interactions, monitor care delivery, and ensure safety checks are consistently conducted. To further enhance early detection and intervention, management will conduct unannounced spot-checks, including night shifts, to ensure residents' comfort, dignity, and adherence to best care practices.
8. Mandatory onsite refresher training on Recognising and Responding to Allegations of Abuse was completed on January 31st and February 14th, reinforcing detection, prevention, and reporting procedures.
9. Additionally, scenario-based safeguarding workshops will be introduced by the Regional Manager to enhance staff competency in identifying, responding to, and managing safeguarding concerns.
10. All new staff receive comprehensive safeguarding training as part of their induction before commencing resident care duties.
11. To ensure residents feel supported and empowered, confidential resident feedback sessions have been introduced, providing an opportunity for residents to raise concerns

in a safe and structured environment.
12. Furthermore, regular family and resident engagement meetings will be scheduled to ensure that all residents and their families are fully informed of safeguarding policies, reporting procedures, and protective measures in place.
13. Ongoing audits and reviews of care practices will be conducted to maintain continuous compliance with safeguarding policies and best practices.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Residents' individual activity care plans have undergone a comprehensive review, and a structured activities schedule is currently under evaluation to ensure activities are delivered in line with assessed needs, personal interests, and abilities.
2. A Residents' Satisfaction Audit commenced on February 18th, with results to be used in informing the weekly activity schedule, ensuring it reflects resident preferences and promotes meaningful engagement.
3. Dedicated staff have been assigned to oversee, coordinate, and facilitate engagement programs, ensuring that residents receive appropriate social stimulation. A meeting was held on February 26th between these staff members and senior management to further enhance the social activity calendar for the home.
4. Regular resident feedback sessions are now conducted to assess activity preferences and participation levels, as well as to identify areas for improvement. Residents have also been invited to join and actively participate in the newly implemented Residents' Social Engagement Committee, allowing them to contribute direct input into activity planning, home initiatives, and social events.
5. To further broaden opportunities for social inclusion, additional volunteer and community engagement initiatives are being introduced to promote external engagement and meaningful connections for residents.
6. Personal care services are now scheduled in accordance with resident preferences, ensuring that care is delivered in a person-centred manner.
7. A daily handover process has been implemented to ensure that resident choices are clearly communicated and accommodated. This process is monitored and supervised daily by a member of the management team, ensuring consistency and adherence to resident-led care planning.
8. All care provided is monitored and now recorded in real-time at the point of care using newly installed tablets in each wing, ensuring accuracy and compliance.
9. In addition, staff engage in daily safety pauses and toolbox talks, reinforcing the importance of resident autonomy and dignity in care provision by the Person in Charge.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	26/02/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	18/02/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/03/2025

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	26/02/2025
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.	Substantially Compliant	Yellow	26/02/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	18/02/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	14/02/2025
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of	Substantially Compliant	Yellow	14/02/2025

	and responses to abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/01/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	01/03/2025
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 the rights of other residents.	Substantially Compliant	Yellow	26/02/2025