Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Whitmore Lodge
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	07 May 2026
Centre ID:	OSV-0005811
Fieldwork ID:	MON-0049642

About the designated centre

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

Whitmore Lodge is an eight bedroom unit situated on a campus based setting in Co. Louth. The centre can support eight male and female adults who require nursing support due to changing medical needs. The centre is nurse led 24 hours a day. Health care assistants also play a significant role in supporting residents here. There are six staff allocated to work during the day with residents and three staff at night time. Household staff also work during the day. The person in charge is a qualified nurse and works on a full-time basis in this centre. Residents are supported to access community facilities in line with their assessed needs. Two buses are available to facilitate the residents accessing their community. Other activities are available in the centre which includes reflexology and music therapy. This centre is also approved as a learning environment for student nurses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 May 2026	14:00hrs to 20:30hrs	Anna Doyle	Lead
Friday 8 May 2026	10:10hrs to 16:30hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Overall, this centre was well-resourced and the staff team were promoting person-centred care based on the assessed needs of the residents. The residents looked well cared for, were treated with respect and in general appeared to have a good quality of life. However, some improvements were required in a number of regulations to assure a safe quality service to the residents at all times. Risk management required significant improvements due to a number of risk assessments in the centre requiring attention. Improvements were also required under general welfare and development, records, residents' rights, governance and management, and notification of incidents.

Over the course of the inspection, the inspector met all the residents, the staff on duty and the person in charge. Two staff met with the inspector formally, to discuss their views on the quality of care provided. The inspector observed interactions over the two days on aspects of the care provided and the care interventions outlined in the residents' personal plans. The inspector also reviewed records specific to the residents care, and the governance and management arrangements in this centre.

Some complaints and compliments that had been recorded in the centre were also reviewed. There were several compliments recorded from family members about the quality of care provided to the residents in the centre including the care and support provided to residents who were nearing end-of-life. One family complimented the staff on arranging a dinner for a special celebration for the family, which they said was very important to them as this was the first opportunity for a number of years that they had celebrated this type of event together.

The inspector also observed where staff had raised complaints on behalf of residents regarding two incidents where the staff numbers had been reduced in the centre due to unplanned absences. While the inspector found that this had been investigated, responded to and risk assessed, the risk assessment did not address how this would be fully managed in the centre going forward, to assure that staffing levels were in line with the assessed needs of the residents. The inspector was also assured that on both of the days that the staff numbers were reduced, that no residents were unduly impacted by this shortfall. This is discussed under Regulation 26: Risk management.

The inspector observed that staff interactions with residents was caring, supportive and respectful. Staff were observed informing residents about what was about to happen. For example; one staff member informed a resident what medicine they were about to administer to them and explained what it was for. They also informed the resident that the medicine was being administered with the resident's favourite food.

The residents living in the centre had specific eating, drinking and swallow plans in place which outlined the specific food consistency that they required due to swallow difficulties to prevent the risk of choking or aspiration. The inspector observed a staff member following the interventions outlined in a resident's plan. For example, the plan stated that the resident should be in an upright position when having meals and drinks, and the staff member was observed calling for assistance to assure that the resident was in the correct position. The inspector also observed that all staff had been trained to assist residents with their feeding eating and drinking plans and to respond to an incident of choking in such an event. There were menu plans in place for each day, which were planned around the residents' likes and dislikes and a sample of those plans viewed by the inspector found that the menus were varied and nutritious, while also taking account of the residents' likes and dislikes. However, not all menu plans were available for each week. This required improvements as a record of all food provided in the centre should be stored in the centre. It was also noted that the times residents had their last meal of the day was not recorded in their daily notes or the handover to staff. However, this was addressed on the first day of the inspection by the person in charge.

The residents living in this centre, had been admitted due to life limiting conditions, such as mid-stage dementia or because they could no longer be supported in their home due to their changing needs. Residents were supported to engage in activities based on their assessed needs on the day of any chosen activity. For example, some days, even though an activity was planned, the resident may not have been well enough to go or may not have wished to go. Some residents, however liked to go out every day or were supported by staff to go out to different events, in line with their interests and hobbies.

Two residents for example, who liked football and rugby had recently been to a rugby match in Dublin. Residents also had goals in place which were centred on things that were important to them prior to living in this centre. For example, it was very important for one resident to visit a family member’s grave every year and staff ensured that this was still facilitated. Each day a specific activity was planned for residents in the centre. These included reflexology and music therapy. It was also observed in some residents’ plans that they liked painting and completing jigsaws, however, there was no evidence of these activities taking place in some of the daily records viewed. While staff reported that these residents were no longer interested in these activities, their plans had not been updated to reflect this. The inspector also found that one to one activities for residents in the centre could be improved in line with their wishes and preferences and needs. For example; residents had memory boxes and family albums created which can be a good way of spending one to one time with residents, however there was no evidence of these activities being conducted with the residents who had them.

The centre was clean and homely and residents had been able to bring their own personal possessions with them. They were decorated in a homely manner even though the setting was more of a clinical setting. The residents' bedrooms were spacious and had plenty of storage space for them to store their personal belongings. One resident showed the inspector their bedroom and they said they

liked it, it was furnished with things that were important to the resident, such as family photographs and their own personal possessions.

Some residents had specialised beds and mattresses and some had assistive devices, such as devices to alert staff at night time that the resident was awake, and moving and may need support. A staff member showed the inspector how this assistive device worked, and it was working on the day of the inspection. However, the inspector found from viewing records that while specialised beds and mattresses were being serviced as required by the manufacturer's guidelines, some of the records for other devices and aids were not available in the centre. This is discussed under Regulation 26: Risk management of the report.

There was adequate bathrooms and toilets for residents to use which were equipped with specific adapted baths and showers for residents who needed these. The inspector observed on the first day of the inspection that staff were flushing taps in the centre to mitigate against the risk of legionella. The staff were aware that this was to be completed at specific times during the day, and that water being used in the centre for consumption was from bottled water only. However, as discussed under Regulation 26: Risk management, the risk assessment in place to address this risk was not comprehensive, and it did not outline all of the controls in place to minimise the risk to residents.

The inspector observed that while some areas of the centre required attention, for example, some of the paint work needed to be addressed, and one resident had picked colours to paint their bedroom, the registered provider was identifying these improvements through their own audits, and there was a plan in place to address them.

The staff were observed responding to the needs of the residents in a timely manner and where a resident requested something or used other non-speaking communication gestures, staff went to the resident to see what they wanted or to provide reassurance to them.

On the day of the inspection residents were observed going for walks, relaxing watching their favourite programmes on TV, and some liked to go for short naps in the afternoon. The inspector observed that when these residents were having naps, their rooms were dark, soft music was playing in the background for those who liked it, and the staff were ensuring that the environment was quite.

Residents were supported to keep in touch with their family and friends. The inspector observed from reading residents' plans and viewing the visitors book that family members visited regularly. One of the staff members gave an example of how a family event for one resident was organised around the residents' interests. For example, the resident liked football and staff had organised for family members to visit so as the resident and their family could enjoy the match together.

Resident meetings were held every week in the centre. A review of these records showed that residents were informed about things that were happening in the centre, and that their views were considered. As an example, one record showed that a resident had asked for additional items to be purchased for them. Another

resident who was non-speaking, was asked by staff it they too would like additional items to be purchased that week and the staff had noted that the resident had smiled indicating that they wanted these items purchased. However, some improvements were required in these records, as it was not clear from the next meeting minutes whether these actions had happened for the residents concerned.

The inspector observed that residents had access to food they liked, there was a small coffee dock area, where residents could choose a variety of drinks or snacks. One of the residents was observed being supported by staff to choose some of these snacks on the day of the inspection.

Notwithstanding the improvements required in some of the regulations inspected, the inspector found that residents were supported with their healthcare needs in a caring environment by a team of staff who were caring, attentive and knowledgeable around the residents' needs and respectful of their wishes on a day-to-day basis.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of care and support provided to the residents.

Capacity and capability

There was a defined management team in the centre at the time of the inspection, who were responsible for the care and support provided to the residents living here. The centre was adequately resourced and the registered provider had systems in place to ensure that the services provided were being monitored and reviewed. However, some improvements were required in some regulations inspected, and risk management was found not compliant. As a result the inspector found that improvements were required under governance and management also, as the registered providers own audits and reviews of the service had not picked up on the improvements required on this inspection, particularly in relation to risk management.

Regulation 14: Persons in charge

The person in charge had the appropriate qualifications, skills and experience of working in health and social care settings. They were employed on a full-time basis in this designated centre. The person in charge demonstrated a good knowledge of the regulations. They were open and transparent during the inspection process, and

were committed to providing a safe, quality service to the residents living in the centre.

The staff said they had opportunities to see and speak with the person in charge on a daily basis, and the person in charge also conducted staff meetings and supervision meetings with staff. The person in charge also had regular formal meetings every two weeks with their line manager regarding the quality and safety of care provided to the residents in the centre.

Judgment: Compliant

Regulation 15: Staffing

The centre was adequately resourced and included a staff team of nursing staff, health care assistants, a social care worker and two household staff. Six staff worked during the day, and three staff at night time. There was always at least one nurse on duty for each day and night shift.

A planned and actual roster was maintained, showing the staff that worked each day in the centre. A review of a sample of rosters worked in December 2025, March and May 2025 showed that the staffing arrangements outlined above were in place. This review also showed that where relief staff were employed, they were for the most part the same consistent staff members. However, as referenced earlier, the staff had raised two complaints on two occasions when shifts could not be filled due to unplanned absences, a risk assessment had been conducted following this, and as referenced under Regulation 26: Risk management of this report, this needed to be reviewed.

On call arrangements were in place by senior managers on a 24 hour basis should staff need guidance, assistance or to report incidents or concerns in the centre.

Staff files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were required to complete specific training to meet the needs of the residents and mandatory training required by the registered provider. At the registered providers last quality and safety review of the centre in April 2026, it showed that some staff were due refresher training in certain areas, and this was planned for at the time of this inspection. The training provided included:

- Antimicrobial Resistance and Infection Control (AMRIC)- Basics of Infection & Prevention Control
- AMRIC - Hand Hygiene
- AMRIC - Personal Protective Equipment
- AMRIC - Respiratory Hygiene and Cough Etiquette
- AMRIC - Standard and Transmission-Based Precautions
- AMRIC- Management of Blood and Body Fluid Spillages
- Safeguarding of Vulnerable Persons
- Fire Safety
- Feeding, Eating, Drinking and Swallowing
- Crisis Prevention Intervention
- Manual Handling (including people handling)
- Basic Life Support
- Assisted Decision Making
- Human Rights-Based Approach to Care

Some staff had also completed training on dementia care. However, as discussed under Regulation 23: Governance and management this required review, given that dementia was an identified need for some of the residents in the centre and not all staff had completed it.

Staff were also provided with formal supervision twice a year. This enabled staff to discuss their personal development and raise concerns about the quality of care if they had any. At the registered providers last quality and safety review of the centre in April 2026 it was found that some staff supervision records were not up to date. The person in charge had a plan in place to address this in the coming weeks. A sample of supervision records reviewed by the inspector found that staff had not raised any concerns about the quality of care.

The inspector spoke with a number of staff over the course of the inspection and met with two staff formally, who demonstrated a good knowledge of the residents' healthcare needs.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre, showing the residents living there at the time of the inspection. It also recorded previous residents who had resided in the centre and the date from which they no longer resided there.

Judgment: Compliant

Regulation 21: Records

Under the regulations, a registered provider is required to have specific documents that are available for inspectors when they are conducting inspections. At this inspection there were a number of records that required review. These included:

- Records pertaining to the food served to residents in the centre.
- The assessment of need conducted for residents with dementia did not determine the different stages that a resident was at in order to inform their future plan of care.
- Some sections of the end-of-life plans for residents were not completed.

Judgment: Substantially compliant

Regulation 23: Governance and management

The designated centre had governance and management arrangements in place, which included auditing and reviewing the care and support provided. However, it was unclear sometimes who was accountable for some service areas. For example; as referenced under risk management it was unclear who had clear oversight over the management of servicing the equipment. The inspector also found that the issues found on this inspection in relation to risk management had not been highlighted through the providers own audits.

A training needs analysis was not completed periodically for all grades of staff (including agency and or on-call staff) to inform what relevant staff training and refresher training was required to support the residents' needs and or changing needs in the centre. For example, the centre supported residents who had dementia, however it was not clear whether all staff should have this training, despite the fact that it was an assessed need for some of the residents.

The person in charge was employed full-time in the organisation. The person in charge reported to a director of care, who was also accountable for the care and support provided. The registered provider also had other directorates within the organisation to oversee services like risk management, human rights issues and human resources.

There were adequate resources in place to support residents achieving their individual personal plans, and in line with the assessed needs of the residents.

The registered provider had personnel appointed to conduct a six monthly unannounced quality review, along with an annual review of the designated centre.

Arrangements were in place to ensure staff could exercise their personal and professional responsibility for the quality and safety of the services that they were delivering. This included monthly staff meetings and arrangements in place for staff supervision meetings and staff appraisals. A recent audit of the centre in April 2026

showed that some staff had not had their supervision completed. However, the person in charge had a plan in place to address this.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed by the inspector and found to meet the requirements of the regulations. It detailed the aims and objectives of the service and the facilities to be provided to the residents.

This document had also been reviewed in February 2026 and the person in charge was aware of their legal remit to review and update the statement of purpose on an annual basis (or sooner) as required by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Overall, while the person in charge maintained a record of all incidents that had occurred in the centre, one had not been notified to the Chief Inspector of Social Services in line with the regulations. The inspector found however, that the incident had been reported to other relevant authorities and had been investigated by the registered provider.

Judgment: Substantially compliant

Quality and safety

Resident's healthcare and emotional needs were being met in the centre and the staff team knew the residents well.

However, the registered provider did not have clear risk management arrangements in place for some potential risks in the centre. This resulted in risk management being found not compliant on this inspection.

Improvements were also required under residents' rights and general welfare and development, to assure that residents were included in all decisions about their care

and support and to ensure that residents had access to activities or hobbies in the centre on a day-to-day basis.

Regulation 12: Personal possessions

Residents could access their personal property, possessions or finances when they wanted to. They were provided with statements from financial institutions showing how much money they had in their personal accounts. The staff supported the residents to manage their financial affairs and maintained records (including receipts) of when residents spent their money to assure accuracy and transparency. As discussed under Regulation 9: Resident rights of this report, however some improvements were required to ensure that residents understood and had choices around spending the money they held in financial institutes.

The registered provider had systems in place to assure that the records stored around residents monies were maintained to assure accurate records of transactions, with corresponding receipts for these transactions. A sample of these records reviewed by the inspector found no discrepancies in the records maintained at the time of the inspection, and that where discrepancies had been observed through previous audits, they had been investigated.

The residents had adequate storage to store their personal possessions and the staff maintained a record of what specific items residents owned in the centre.

There was space for residents to store their clothes and staff supported residents to launder their clothes in the centre.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to keep in touch with family, and staff helped the residents to arrange visits with their family members. Residents were supported to have meaningful activities in line with their preferences and wishes. However, some improvements were required in one to one activities for residents each day.

Each day a specific activity was planned for residents in the centre. These included reflexology and music therapy. It was also observed in some residents' plans that they liked painting and completing jigsaws, however there was no evidence of these activities taking place in some of the daily records viewed.

While staff reported that these residents were no longer interested in these activities, their plans had not been updated to reflect this and the inspector found

that one to one activities for residents in the centre could be improved in line with their wishes and preferences.

For example; residents had memory boxes and family albums created which can be a good way of spending one to one time with residents, however there was no evidence of these activities being conducted with the residents who had them on a day to day basis.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The registered provider had a policy on the monitoring and documentation of nutritional intake to guide practice. For example, the policy stated that if concerns were noted with a resident's nutritional intake, then additional records should be maintained and the resident should be referred to the relevant doctor or health and social care professional for advice. At the time of the inspection there were no concerns with any of the resident's nutritional intake.

Records were in place to assure that residents were monitored for any sudden weight loss. For example; resident's weights were checked on a monthly basis and a sample viewed by the inspector showed no concerns.

There were adequate amounts of food, refreshments and beverages available to residents including a coffee dock that was stocked with drinks, snacks and alcoholic beverages to cater for all of the residents' preferences. The staff were observed providing drinks and meals to residents in a respectful manner and the meals were in line with their personal preferences. For example, one resident liked specific desserts, whereas another resident liked take-way chips and this was facilitated.

There were specific eating, drinking and swallow plans in place which outlined the specific food consistency that a resident may require due to known swallow difficulties and to prevent the risk of choking or aspiration. The inspector observed a staff member following the interventions outlined in one resident's plan. For example, the plan stated that the resident should be in an upright position when having meals and drinks and the staff member was observed calling for assistance to assure that the resident was in the correct position prior to giving the resident their meal. Staff had also been provided with training to assist residents with their feeding eating and drinking plans and to respond to an incident of choking.

There were menu plans in place for each day, these were planned around the residents' likes and dislikes and a sample of those viewed by the inspector were varied and nutritious while also taking account of the residents' preferences. However, not all menu plans were available for each week which is discussed under Regulation 21: Records of this report. It was also noted that the times residents had their last meal of the day was not recorded in their daily notes or the handover to

night staff for example. The inspector was assured that this improvement was addressed on the first day of the inspection by the person in charge.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place, to guide how risks and adverse incidents should be managed in the centre. However, there were a number of risk management processes in the centre that needed to be improved resulting in a judgement of not compliant under this regulation.

The inspector observed on the first day of the inspection that staff were flushing taps to prevent the risk of legionella in the centre. The staff were aware that this had to be completed at specific times during the day, and according to staff bottled water was being used in the centre for consumption rather than tap water. However, the registered provider had a risk assessment conducted regarding this potential risk that was not comprehensive and did not outline the control measures in place in all scenarios. For example, some of the control measures in place, included, flushing the taps four times a day and that this should be recorded each time. The water in the centre was also to be tested each week to confirm that legionalla was not present. However, while the control measures stated that flushes should be increased to five times where required, it did not outline what additional precautions should be taken, if legionella was present in the water tests conducted to mitigate the risks to residents. The inspector also found that the records maintained for the water flushes conducted each day had gaps in the records viewed.

The registered provider also had a standard operating procedure in place regarding water hygiene to guide practice in this area. However, the inspector found that this policy required review as it did not indicate whether staff were required to have training on this specific risk, and it did not guide practice to state what should occur when the water test came back positive for legionalla bacteria, what additional precautions should be taken, or the personnel responsible for acting on these positive results and deciding on the precautions that should be followed.

The inspector also found that there was also no complete record to show when the equipment had been serviced in the centre, to assure that it was in good working order. There was also confusion on the day of the inspection about who was accountable for planning the service dates for equipment and ensuring that the records for these services were stored in the centre.

A risk assessment in place for when there was a staff deficit in the centre due to unplanned leave, did not include the control measures in place to ensure that the assessed needs of the residents at the time of this inspection would be met on any given day. This was addressed on the first day of the inspection to assure that staff

would have access to additional staff should this situation arise in the centre in the future.

The details included in one resident's manual handling risk assessment had not been included in the resident's intimate care plan. For example, the number of staff required to support the resident, and how the care was delivered by these staff members was not recorded.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had systems in place to assure that medicines were ordered, stored securely, and that there was a system in place for the disposal of medicines.

The inspector observed from talking to staff and reviewing a sample of practices in the centre that resident's medicines were administered and monitored in line with best practice. For example, all of the medicines were stored securely in the centre, any allergies that a resident had were also documented on the relevant records, and residents' medicines were reviewed at least every three months by their prescribing doctor. Medicine reconciliation records were also maintained by staff to assure that medicine errors were not occurring in the centre. This included records relating to the receipt and administration of controlled drugs. The staff member was aware of the reason the medicines were prescribed to the residents. Residents were informed by staff that they were administering their medicine and the reason it was being administered for.

There was a system in place to assure that if medicine errors occurred, that they were recorded, reported and analysed within an open culture of reporting. At the time of this inspection, there had been no medicine errors recorded in this centre in recent months. The person in charge conducted regular audits in the centre for medicine management and where improvements were identified they were responded to.

The registered provider had a committee in the organisation to assure best practice in medicine management in each of the designated centres under their remit.

An assessment had been completed for each resident to determine if they could be responsible for their own medicines. At the time of this inspection, all of the residents were assessed as requiring support from staff to manage their medicines.

Judgment: Compliant

Regulation 6: Health care

Each resident's personal plan contained an up to date assessment showing the health and well-being needs of the residents. The inspector found from reviewing a sample of residents' personal plans that the person in charge and the staff were proactive in referring residents to health and social professionals, such as occupational therapist, speech and language therapist and a physiotherapist, as well as clinical nurse specialist and doctors where required.

Recommendations following these referrals were being implemented. For example, a recommendation following a medical review had shown that a resident required a follow up investigation and this was in progress at the time of this inspection. Residents were also afforded the right to refuse these recommendations and their doctor had been informed of this decision.

A sample of plans viewed by the inspector showed that end-of-life plans were in place for residents, to assure that their wishes were recorded. Plans had been conducted through consultation with family members to support the residents' wishes. Where there was specific measures to be followed when the person was nearing their end-of-life, this had been discussed with relevant staff, family members, the resident's doctor and other relevant health and social care professionals to assure that the residents' will and preferences were considered. The staff were familiar with these end-of-life care decisions and from a sample viewed by the inspector they had been reviewed in line with the registered provider's policy.

Residents had been supported to make decisions and avail of national screening services, if they wished.

Judgment: Compliant

Regulation 8: Protection

All staff had completed training in safeguarding vulnerable adults. Where incidents had been reported to the Chief Inspector of Social Services, the provider had reported it to the relevant authorities and had taken steps to safeguard residents. One safeguarding incident which had not been notified to the Chief Inspector as referenced under Regulation 31: Notification of Incidents, had been investigated and measures had been put in place to assure that this did not occur in the future.

Residents had been provided with information on staying safe in the centre and on how to make a complaint if they did not feel safe or protected. The inspector observed that staff advocated on behalf of residents where some potential concerns with the care and support of residents were observed. For example; if a resident had sustained a bruise or any injury that had not been witnessed then this was referred to the designated officer in the organisation as a possible safeguarding concern, for review to assure transparency and to decide on the course of action (if any) to be taken.

One staff who met with the inspector was aware of the different types of abuse and the reporting procedures in place should an incident occur. The person in charge, and two staff informed the inspector that they had no concerns about the quality and safety of care provided.

Residents had intimate care plans in place to guide how they liked to be supported. While staff spoken with were aware of these supports, one intimate care plan did not include the details included in the resident's manual handling risk assessment as discussed under Regulation 26: Risk management of this report.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found some good examples of where residents' rights were promoted and protected in the centre.

However, improvements were required so as each resident could exercise choice and control in their daily life in accordance with their preferences.

These improvements included:

- Being informed of the amounts of money they had in their bank accounts to assure that residents got to decide what they would like to do with this money.
- The records regarding residents' meetings needed more detail about how residents were included in the discussions and decisions being made and the follow up on actions agreed at meetings.

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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Whitmore Lodge OSV-0005811

Inspection ID: MON-0049642

Date of inspection: 08/05/2026

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • Records pertaining to the food served to residents in the centre are in place and filed in the designated centre each week. • The Residents dementia plan of care was reviewed and assessment updated to reflect the stage of the resident's dementia and the support needs required, as stated in the CNS in Dementia review report. The residents baseline dementia assessment is in the current IPP. • All end-of-life plans were reviewed and updated to reflect the wishes of the individual.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge has developed a new training matrix for monitoring of staff training which includes Dementia training. This will be reviewed monthly by The Person in Charge. • All Staff who have not received training in Dementia will be scheduled for same. • A new electronic shared folder has been set up to store all maintenance certificates and service records.	

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge has submitted a retrospective NF06 and will ensure that all statutory notifications are submitted within the allotted timeframe.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
All residents' meaningful day plans were updated to reflect residents' currents likes and preferences. A new Meaningful day schedule and recording sheet has been implemented to ensure residents have allocated 1:1 time engaging in activities of their choice.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Legionella risk assessment updated and reviewed to include the following existing control measures:
• Water quality management folder in place where all water quality records. are stored.
• Water quality management will be an agenda item at team meetings.
• PIC is responsible for reviewing records pertaining to water quality management.
• Accessible information available for residents and staff.
• All Staff are trained in AMRIC on Hseland.
• PPE available if required.
• Training available on Hseland: "Legionella Module 1 The importance of proper flushing."
• In the event of a suspected or detected legionella report the Maintenance Supervisor or Operations Manager will convene a review meeting to discuss actions.
• Sampling reports are sent directly to the Maintenance Supervisor or Operations

Manager, and these will be share with the PIC
• Guidance available from "National Guidelines for the Control of Legionella in Ireland, 2009."
• Water Testing Temperature Checks are carried out monthly.
• A record of all hot and cold-water outlets being flushed daily will be maintained.
• Following a positive legionella result additional flushing occurs 5 times within 24 hours.
• All water outlets are cleaned and reflect IPC guidelines.

Local procedure is currently in draft awaiting approval with an estimated time frame for completion of 25.6.2026

The residents' manual Handling risk assessments are now reflected in their intimate care plan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• All residents will be informed of the amounts of money they have in their bank accounts to ensure that they can decide what they would like to do spend it on. This will be reflected in their IPP

• All staff have been made aware that the records regarding resident's meetings require more detail on how they were included in the discussions. The Person in Charge will review residents' meetings minutes monthly to ensure follow up of actions which were agreed took place.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	08/06/2026
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	08/06/2026
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for	Substantially Compliant	Yellow	08/06/2026

	inspection by the chief inspector.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	09/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	25/06/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Substantially Compliant	Yellow	10/06/2026
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in	Substantially Compliant	Yellow	16/06/2026

	accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			