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:	Brampton Care & Rehabilitation Centre
Name of provider:	Brampton Care Ltd
Address of centre:	Main Street, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	25 June 2025
Centre ID:	OSV-0005812
Fieldwork ID:	MON-0046905

About the designated centre

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

Brampton Care Home is located in the heart of Oranmore town, Co. Galway. The designated centre cares for residents with aging related health issues inclusive of physical, psychological and social concerns. The service cares for both male and female residents that are aged 18 years and over. The care extends to those with dementia, cognitive impairment, mental illness, intellectual disabilities, physical disabilities and chronic physical illness. There is 24 hour nursing care available in the centre. The centre is laid out over three floors of a four storey development. Residents have access to outdoor gardens. The centre has 94 beds, 82 single occupancy en-suite rooms and six double occupancy en-suite rooms. All bedroom accommodation is situated on the second floor and third floor which are accessed by two lifts. Each floor also contains a sitting room, dining room and kitchenette.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	86

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
Wednesday 25 June 2025	08:30hrs to 17:45hrs	Fiona Cawley	Lead
Tuesday 1 July 2025	10:50hrs to 16:25hrs	Fiona Cawley	Lead
Wednesday 25 June 2025	08:30hrs to 17:45hrs	Catherine Sweeney	Support
Tuesday 1 July 2025	10:50hrs to 16:25hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Brampton Care and Rehabilitation Centre is situated in Oranmore, County Galway. The centre is a purpose-built, four-storey facility providing accommodation for 94 residents over three floors. This unannounced inspection took place over two days. There were 86 residents accommodated in the centre on the days of the inspection and eight vacancies.

Feedback from residents was that staff were kind and caring. However, a number of residents expressed dissatisfaction with the quality of the service provided. For example, in relation to the length of time they had to wait for assistance and support from staff, the quality of food provided, and the provision of activities.

On the first day of the inspection, inspectors arrived at the centre mid-morning and were met by a director of nursing. Following an opening meeting, inspectors conducted a walk through the building, giving an opportunity to review the living environment, and to meet with residents and staff. A number of residents were having breakfast in the dining areas and bedrooms, while other residents were relaxing in communal areas. Other residents were being assisted and supported by staff with their personal care needs.

Residents' living and bedroom areas were located on three floors of the building which were serviced by accessible lifts. There were a number of communal areas available to residents throughout the centre for rest and recreation including, sitting rooms, day rooms, dining rooms and a coffee shop. These rooms were observed to be bright and spacious and styled to create a homely living environment for residents. There was sufficient space available for residents to meet with friends and relatives in private. There was also an oratory available which provided a tranquil space for residents. Bedroom accommodation comprised of single and twin occupancy rooms, all of which had en-suite facilities. There was sufficient space available in bedrooms to store residents' personal belongings, including lockable storage. Residents were supported to decorate their bedrooms with personal items of significance, such as ornaments and photographs. All areas of the centre were styled and furnished to create a comfortable and accessible living environment for residents.

There was safe, unrestricted access to outdoor areas for residents to use. These areas contained suitable garden furniture and seating.

Over the course of the two days, inspectors spent time chatting with residents, staff and visitors, and observing staff and resident interaction. Staff were observed to be busy assisting residents with their needs throughout the day. Inspectors observed that staff allocation and supervision was inadequate and ineffective over the two days of the inspection. For example, during the midday meal-time, residents were observed to be unsupervised and did not receive assistance when required. Some

instances of inappropriate manual handling techniques were also observed when staff were moving or transferring residents, posing a risk to residents' safety.

Inspectors interacted with a large number of residents throughout the inspection. Those residents who spoke with inspectors were very happy to chat about life in the centre. Some residents told inspectors that staff were good to them and that, overall, they had everything that they needed. 'I like it here, the people are kind', 'everything is ok' and 'they're very good to me' were among some of the comments made by residents. However, a substantial number of residents told inspectors that they often had to wait extended periods of time for help from staff. One resident said 'it can take up to a half an hour for someone to come and help me after I ring my bell'. Another resident said that they had to wait 'excessive' times for their bell to be answered and that this happened consistently. One resident told inspectors that they could not get up at the time of their choice each day as the staff were too busy with other residents.

Friends and families were facilitated to visit residents, and inspectors observed many visitors coming and going throughout the day. Inspectors spoke with a number of visitors who were generally satisfied with the care provided to their loved ones. However, a small number of visitors expressed their dissatisfaction about some aspects of the service. One visitor spoke at length about the call-bell response times and described how they themselves had used the call-bell, on behalf of their relative, earlier in the day and that no staff attended to them. Another visitor told inspectors that they often observed communal areas left unsupervised by staff, especially at the weekend, and that this was a cause of concern as many residents were at risk of falling.

Many residents spoken with said that they found their days long in the centre. Residents reported that 'there was nothing to do'. Residents told the inspectors that they would like to see more activities that were 'easy to do and a bit of fun'. An activity schedule was on display. The three activities scheduled for day two of the inspection were religious activities; singing hymns, saying the rosary, and reading scriptures. There was no alternative activity scheduled, and residents, who did not wish to participate in scheduled activities, were observed spending extended periods of time with limited social engagement.

On the first day of the inspection, the lunch-time experience was observed to be inconsistent throughout the centre. While the mealtime on the ground floor was observed to be a pleasant, social occasion, residents were observed waiting lengthy times for their meal to be served. The lunch on the second floor was observed to be chaotic and unsupervised. The service of meals was poorly organised with minimal communication between staff and residents. Dining tables were not set appropriately for the meal, and residents were served their meal on a tray containing their main meal and dessert. Dessert portions were prepared well in advance of the main course being finished by residents resulting in many residents receiving a bowel of melted ice cream. Many residents were unsure what food they would be served as they could not remember what they had ordered the day before. One resident was observed to be served a large slice of meat which they were not able to eat without assistance to cut. Staff did not recognise that this resident

required assistance. By day two of the inspection, the lunch time service on the second floor had been reviewed and it was observed that the dining room tables were appropriately set, and residents were facilitated to have their meal at the tables. Meals were served by the kitchen staff from a heated counter and desserts were served after the main course. A number of residents told inspectors that the quality of the food was unsatisfactory. One resident told inspectors that food was often served cold and others said that there was poor choice of food available to them.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

This was an unannounced risk inspection carried out by inspectors of social services over two days, to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

Inspectors also reviewed unsolicited information received by the Office of the Chief Inspector in relation to concerns about the management of the centre, in particular, staffing levels and the supervision of staff, resulting in poor standards of care. This information was substantiated on this inspection. Inspectors also followed up on the action taken by the provider to address the non-compliant issues found on inspection in July 2024. Inspectors found that the actions taken were not sufficient to bring the centre into full compliance with the regulations as there were repeated findings of non-compliance with Regulation 23: Governance and management, Regulation 34: Complaints procedure, and Regulation 5: Individual assessment and care plan. Furthermore, training and staff development did not meet the requirements of the regulations.

The findings of this inspection were that the registered provider did not ensure that an appropriate organisational structure and management systems were in place to ensure a safe and high quality service. The supervision of staff and the oversight of care delivery was inadequate, and resulted in poor quality of life for some residents in the centre. As a result, an urgent compliance plan request was issued to the registered provider to urgently address the governance and management arrangements in the centre. This compliance plan was accepted by the Chief Inspector.

The registered provider of Brampton Rehabilitation and Care Centre is Brampton Care Ltd, a company comprised of two directors. Inspectors found that the overall governance and management of the centre was ineffective and resulted in a poor service. While there was an organisational structure in place, the lines of authority and accountability for all areas of care provision were not clearly defined. There was

a person in charge supported by a director of nursing, an assistant director of nursing and three clinical nurse managers. A team of nurses, health care assistants and support staff completed the staffing structure. Inspectors found that responsibilities for care delivery and systems of oversight were being delegated to staff without appropriate levels of support and supervision. This resulted in an overall failure of the governance of the centre, noted particularly by incomplete records, poor communication, chaotic and ineffective care practices, and inadequate incident and complaint management.

Staffing levels in the centre were found to be sufficient for the number of residents and for the size and layout of the centre. However, a review of the roster found that the availability of health care assistants was low and not in line with centre's own statement of purpose. There were 10 health care assistant vacancies on the days of the inspection. Health care assistant rosters were supplemented using staff nurses or agency staff. The registered provider was in the process of recruiting health care assistant staff. There was a high level of staff turnover in the centre, and residents told the inspectors this had an impact on the quality of their lives and the service they received, as new staff were not always aware of their needs, and that they had to keep familiarising themselves with new staff members.

A review of the roster in the centre found that the roster did not include all staff working in the centre and did not reflect the actual hours that staff had worked. There was an electronic and a paper record of the staffing roster. There was also an electronic clock-in system that was used to verify if planned shifts had been completed. This complicated rostering system meant that inspectors were unable to identify changes that had been made to staff rosters, or the total numbers of staff available in the centre. In addition, codes were used to identify staff roles on the roster but these codes were not explained. This system posed a risk to the oversight of staffing levels and staff allocation in the centre, and was not in line with the requirements of the regulations.

Inspectors observed that staff did not receive appropriate levels of supervision and support from the management team. Staff were poorly allocated and supervised in their role. Inspectors observed a poor standard of care in relation to mealtimes and nutritional management, and poor moving and handling techniques. Inspectors spoke with residents who said they experienced long periods of time waiting for assistance. The oversight of nursing documentation was also found to be ineffective. Care plans reviewed were poorly developed and did not clearly describe the intervention required to ensure residents' well-being and safety. For example, inspectors observed two residents who received a modified textured diet for their lunch. Both residents' lunch trays were returned with the meals untouched. Inspectors were informed by staff that one of the residents never eats their meal at lunchtime as they do not like having their dinner in the middle of the day. A review of this resident's daily care plan found that this information was not included in the resident's plan and therefore, there was no intervention in place to ensure the resident had their meals at a time of their choice. A review of the daily food intake charts for these two residents, one hour after the meal time, found that records showed that both residents had eaten their full meals. Recording of inaccurate care

records could pose a risk to residents who are assessed as being at risk of weight loss.

While the provider had systems in place to monitor and review the quality of the service provided for the residents, such as an electronic auditing system, the management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. This was evidenced by inadequate oversight of incidents, complaints, record-keeping and fire safety. Furthermore, there were inadequate systems in place to ensure health and social care was delivered in line with residents' needs.

Inspectors found that there was a system in place to enable staff to report adverse incidents, such as unexplained injuries. A record of all accidents and incidents involving residents that occurred in the centre was maintained. However, incidents were not consistently investigated to establish any factor which may have contributed to the incident, and therefore the management team did not identify or implement necessary improvements to prevent such incidents from recurring.

A review of the complaints records found that the process for managing complaints was not in line with the regulatory requirements. A complaints procedure on display in the centre did not identify the correct complaint officer or review officer. Complaints were not documented or investigated in line with regulatory requirements, and the satisfaction of the complainant was not recorded, as required.

Regulation 15: Staffing

Staffing levels were adequate to meet the needs of the residents, and for the size and layout of the centre. However, a high turnover of staff and ineffective supervision impacted on the continuity and quality of resident care. This is addressed under Regulation 23(1)(a) governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

The registered provider had inadequate arrangements in place to ensure appropriate levels of staff supervision were in place. For example;

- Ineffective allocation of staff, resulting in a substandard level of care delivery.
- Lack of staff supervision, monitoring and support at every level of the organisation, impacting on the delivery of health and social care to residents.

This was evidenced by;

- residents reported waiting long periods of time for their care needs to be attended to
- care staff were not appropriately supervised to ensure that care was delivered in line with residents' assessed needs and care plans
- poor allocation of staff at meal times to ensure residents received assistance in a timely manner
- inadequate provision of activities
- staff were observed to use manual handling techniques that were not safe and did not protect the privacy of residents.
- unsafe fire protection practices such as holding open fire doors with wooden wedges and furniture.
- poor oversight of care delivery documentation

The registered provider was issued with an urgent compliance plan following the first day of the inspection in relation to staff supervision, to ensure residents' immediate well being. The Chief Inspector accepted the plan submitted.

Judgment: Not compliant

Regulation 21: Records

Record management was not in line with the requirements of the regulations. This was evidenced by;

- record keeping was disjointed and difficult to review. For example, the system to record staff rosters was complicated which could impact the oversight of staffing levels and staff allocation.
- records of incident and complaint management were incomplete and therefore information governance systems essential for the quality and safety of the service were ineffective.
- the staffing roster reviewed did not accurately reflect the staff on duty. For example, agency staff were not named on the roster, and the role of staff members was not clearly identified on the rosters.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider failed to ensure that the centre was adequately resourced. Inadequate levels of health care assistant staff resulted in the staffing roster being supported by agency staff on a regular basis. A high turnover of staff was having a negative impact on residents' quality of life.

This inspection found that the registered provider had failed to put in place a management structure that clearly defined the lines of authority and accountability for all areas of care provision, particularly in relation to the supervision and oversight of care delivery. The roles and responsibilities of the management team were not clearly defined, resulting in responsibilities being delegated to staff without appropriate levels of support and supervision.

For example;

- A person in charge, a director of nursing and an assistant director of nursing were on duty on day one of the inspection, however, supervision of a large group of residents with complex care needs was inadequate and resulted in care delivery during this time being sub-standard and not in line with the requirements of regulations.
- Inadequate supervision of resident meal-times. Residents were served food that they could not manage to eat independently, with no support from staff.
- Inappropriate and ineffective manual handling techniques were observed, posing a risk to residents' safety.
- Inadequate oversight of nursing documentation. Care plans had not been reviewed and updated appropriately following significant incidents and complaints received.

The inspection found that the management systems in place to ensure that the service provided was safe or consistently monitored was not effective, particularly in relation to the system in place to supervise, monitor and support staff. This was evidenced by;

- inadequate oversight of incidents, complaints, record-keeping and fire safety
- inadequate systems to ensure health and social care was delivered in line with residents' needs.

The registered provider was issued with an urgent compliance plan on the first day of the inspection to ensure residents immediate well being. The Chief Inspector accepted the plan submitted. By day two of the inspection, some action had been taken to address the deficits in the governance and management of the centre.

The provider had also failed to address outstanding non-compliances found on a previous inspection of the centre, in line with the provider's own time-line. This was in relation to the quality of assessments and care planning.

This a repeated non-compliance.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints management system found that complaints were not managed in line with the requirements of Regulation 34. For example:

- A number of complaints remained unresolved with no time-line identified for resolution; a written response was not provided to the complainant outlining the reasons for the delay in complying with the applicable time-lines.
- The practice around the management of complaints was inconsistent, not all complaints received were fully recorded and a number of complaints did not have any investigations completed.
- Learning from complaints was not identified and shared with staff for on-going quality improvement.
- The management and oversight of complaints in the centre had been delegated to staff who had not been appointed as complaint officers or reviewers, contrary to the centre's own complaint management policy.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

The poor governance arrangements in the centre impacted on the quality and the safety of residents' care in the centre. This inspection found that the arrangements in place to ensure appropriate levels of supervision of staff were not robust and urgent assurances were requested from the provider following the first day of this inspection.

All residents had a number of clinical and social assessments completed however, the quality and appropriateness of some assessments and care plans was inconsistent and care plans did not always contain up-to-date information to guide staff in their care needs. A sample of residents' care records reviewed found that care plans had not been reviewed and updated, in line with the changes in residents' care needs. Where information was available to guide staff, the actions required were not always implemented. This was a repeated non-compliance with further detail outlined under Regulation 5: Individual assessment and care plan.

Residents had access to medical and health care services. Systems were in place for residents to access the expertise of health and social care professionals, when required.

The procedure to protect residents from abuse was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate action to take to protect residents if there is a suspicion or allegation of abuse. However, a review of accidents and incidents in the centre found that a number of unexplained injuries

had not been identified and investigated, as potential safeguarding concerns. This was contrary to the centre's own safeguarding policy.

While there were some opportunities to participate in recreational activities, inspectors observed that residents did not have consistent access to activities in line with their interest or abilities. A number of residents told inspectors that there was little to do and that the days were very long. Inspectors observed some group sessions in communal areas over the two days, such as exercise classes and a quiz. However, while these group activities were taking place, a large group of residents on the second floor of the centre were observed to spend the afternoons with limited social engagement and no access to meaningful activities on both days. Staff informed the inspectors that these residents did not wish to attend the group activity downstairs, however, no alternatives were provided.

Records reviewed found that residents had the opportunity to meet together and discuss relevant management issues in the centre at resident forum meetings. However, issues of quality improvement and concern, identified by residents at these meetings, had not been escalated to the management team and therefore no action had been taken to address the issues. Residents told inspectors that they did not see the point in attending these meeting as no action was taken to address their issues. Inspectors were informed by the person in charge that a resident survey was underway at the time of the inspection, however, no surveys were available for review.

The centre was designed and laid out to meet the assessed needs of residents. Corridors were wide and there were appropriately placed hand rails to support residents to walk independently. There was a sufficient number of toilets and bathroom facilities available to residents. However, inspectors observed that a number of en-suite facilities did not provided grab-rails in the toilet areas.

Call-bells were available in all areas. The centre was bright, warm and well-ventilated throughout, and overall, the centre was clean. However, inspectors observed a number of maintenance issues including visibly damaged walls, doors and items of furniture throughout the centre. Inspectors also observed that items of residents' equipment and items of furniture were inappropriately stored in communal areas and residents' bedrooms.

The quality of the dining experience observed on day one of this inspection was very poor. While residents were observed to wait extended periods of time for their meals across the centre, the service and quality of the lunchtime meal on the second floor was particularly sub-standard. Inspectors observed that residents were not offered an appropriate choice of meals at mealtimes. Staff told inspectors that residents chose their meal preferences the day before. Residents spoken with could not remember what they had ordered the previous evening. One resident told inspectors that they did not like the meat they were served at lunchtime.

Regulation 11: Visits

Inspectors observed visiting being facilitated in the centre throughout the inspection.

Judgment: Compliant

Regulation 17: Premises

The premises was found not to conform fully to the matters set out in Schedule 6 of the regulations. For example;

- there were a number of maintenance issues including visibly damaged walls, doors and items of furniture
- there was inappropriate storage in the centre. For example, hoists, mobility aids and specialised seating were stored in communal areas, residents' bedrooms and bathrooms.
- a number of en-suite facilities did not provided grab-rails in the toilet areas

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

This inspection found that a number of care plans were not up-to-date, while other care plans were not fully implemented. For example;

- One resident assessed as being at risk of falling and who sustained falls in the centre, did not have an appropriate care plan developed.
- The care plans for a number of residents with skin integrity issues were not updated in a timely manner to reflect the care interventions required to support their needs.
- One resident's care plan stated that they required 15 minute safety checks as they were assessed as being at risk of falling. A small number of staff with whom inspectors spoke gave inconsistent information regarding the frequency of safety checks for this resident. Some staff were not aware that the resident was at risk of falling.
- One resident's care plan had not been updated to reflect their mealtime preferences.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to appropriate medical and allied health care professionals and services to meet their assessed needs.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that the registered provider did not take all reasonable measures to protect residents from abuse. For example, a review of incident records found that there were a number of unexplained injuries reported, which had not been recognised as potential safeguarding concerns. This meant that the provider had not considered all factors which may have contributed to the unexplained injuries, and investigations were not completed to rule out potential safeguarding concerns.

Judgment: Not compliant

Regulation 9: Residents' rights

While there were activities provided to the residents on the days of the inspection, residents told inspectors that the scheduled activities were not aligned with their interests or preferences. Residents were observed spending long periods with no social interaction.

Residents were not afforded choice at mealtimes. Similarly, residents said they often experienced delays to care and gave examples of numerous occasions where they could not exercise choice in respect of when they wanted to get up, or be assisted with personal care as a result of staff unavailability.

Although residents' meetings were held in the centre, residents told inspectors that voicing their concerns and attending residents' meetings did not lead to any improvements.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Brampton Care & Rehabilitation Centre OSV-0005812

Inspection ID: MON-0046905

Date of inspection: 01/07/2025

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Revised and updated staff rosters have been implemented to ensure clear allocation of all staff, including agency staff, with appropriate skill mix to meet care needs. Since the inspection, agency dependency reduction plan has been initiated, additional full time healthcare assistants have been recruited, and the use of agency staff has been significantly reduced. Daily staffing allocations are now structured to have better work organisation and to match staff competencies with resident needs and task priorities. Care staff allocation is clearly defined for each dining area to ensure residents receive timely, respectful assistance. Each shift now includes a designated HCA team leader and the nurse on duty oversees staff allocation and care delivery.

A new ADON was recruited in September. ADONs attend daily handovers on each floor and participate in safety pause meetings in the afternoon. Staff education on time management, prioritisation, and person-centred care has been provided to improve responsiveness and reduce delays. CNMs and staff nurses have been educated to provide real-time oversight and support to healthcare assistants, ensuring that delegated tasks meet quality standards and immediate guidance is available when needed. The PIC, ADONs, or DON are present in the centre seven days a week and frequently visit the floors conducting daily observations of practice. They monitor, supervise and provide real time feedback on care delivery particularly during mealtimes and peak care periods to ensure that training received is put in to practice effectively and that a high standard of care is consistently maintained.

A full review of the call bell response times was conducted by the PIC following the inspection, and appropriate actions have been taken. Call bell response times are reviewed monthly to ascertain if residents have been waiting for assistance for an unacceptable period of time. The most recent residents meeting, held on 19th September was positive. A resident satisfaction survey on call bell response time was

conducted by the DON in September and showed a high 87 per cent satisfaction rating. The findings from the survey have been shared with staff to promote awareness of issues arising and to drive continuous improvement. ADONs will continue to educate staff during daily handovers, with a focus on time management, prioritising care and responding to call bells promptly to ensure residents receive timely assistance, improving both safety and satisfaction. They also crucially supervise and monitor care on the floors.

A full review of the dining experience and mealtimes has taken place, and changes have been made to ensure that residents are being supported in a person-centred way by staff, which is supervised by Nursing staff and senior clinical managers. Nurses and CNMs actively supervise mealtimes. Both ADONs are worked closely with team leaders on each floor to develop a guide for staff outlining resident's preferences regarding breakfast and meals. They regularly meet with staff on the floor to improve communication and ensure residents preferences are understood and respected.
Dysphagia training has been organised for staff for 7th and 22nd October 2025.

Additional activity staff have been employed, and there are a variety of activities taking place on a daily basis across each floor, which are tailor made to suit the needs and wishes of residents. Feedback from residents regarding the activities has been sought to ascertain their level of satisfaction with activities provided. Feedback has been generally positive.

Manual handling training was completed for all staff in August. Two staff members are now certified manual handling trainers. Spot checks have been implemented to ensure staff are using safe manual handling techniques while maintaining resident's dignity and privacy during the care. Further refresher training is scheduled for October 2025 to ensure ongoing compliance and to include new staff. Staff completed the restrictive practices training on 2nd and 4th of September 2025. An additional training session is scheduled for 30th September.

Wedges and furniture used to hold open fire doors were removed immediately. All staff received re-education on fire safety protocols, emphasising the importance of keeping fire doors closed. Specific staff members are now assigned on the roster to carry out regular spot checks to ensure compliance with fire safety policies.

The PIC, DON, and ADON have undertaken a comprehensive review of resident care records, assessments, care plans with the registered nurses. Areas for improvement were identified, and 1:1 refresher training session have been completed for all nursing staff, focusing on proper documentation practices and the importance of accurate, timely records. Guidance has also been provided on developing person centred care plans. Residents, or their nominated representatives have been involved in the review of the care plans, and their input has been recorded. On site care planning training was conducted for nursing staff on 8th September 2025. Healthcare assistants now have access to read and understand resident care plans to guide the delivery of personalised care. A resident care needs guide has been developed to support staff in understanding and meeting each resident's specific needs. Safeguarding awareness training is scheduled for all staff on the 2nd of October 2025. Two groups of staff will participate in a series of four Caru workshop sessions from October 2025 to December 2025 focussing improving the quality of care by promoting dignity, respect, and support for residents

and their families.

A performance review system has been introduced to monitor staff effectiveness, accountability, and to address any gaps. Care outcome and concerns will be monitored through regular audit to assess impact of staffing and supervision improvements.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

All incidents, falls, complaints and concerns have been reviewed from the start of 2025. All complainants have been contacted to ensure that they are satisfied with the measures taken to resolve the complaint. Any trends have been identified and action plans have been put in place to ensure that there is organisation wide learning from the complaints received to improve levels of satisfaction with the service. Incidents and falls have been analysed to identify any specific risks. Trends have been identified, action plans put in place to address identified trends, and new initiatives implemented to reduce the risk of incidents and falls. This is being reviewed monthly in clinical governance and management meetings to ensure that measures are effective.
Rosters are available which detail which staff are on duty in each department, and this also identifies the role of each staff member. Changes to the roster are made in red pen to ensure that changes can be clearly identified. Any agency staff that work in the centre are identified and their names recorded on the appropriate roster.

Regulation 23: Governance and management	Not Compliant

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

A comprehensive staffing needs assessment was conducted and additional staff have been employed to ensure that there is adequate supervision of residents. A new clinical administrator has been recruited in September to ensure that there are always sufficient staff available to meet the assessed care needs of all residents. The DON will supervise the clinical administrator and periodically review staffing levels based on resident's dependency needs. The HR team is focusing a recruitment drive to fill the open positions, alongside the implementation of retention strategies aimed at minimizing staff turnover. A revised organisation structure has been implemented, clearly defining lines of authority, accountability, and delegation. Job descriptions for all leadership roles (PIC,

DON, ADON) have been updated to reflect clear responsibilities and expectations. A twice weekly meeting takes place between PIC and DON to discuss specific issues relating to quality improvements in resident's care. The DON supervises the ADONs and meets with them daily to review incidents, staffing, complaints, and operational concerns. The PIC meets biweekly with the provider, DON, HR department, accounts manager and facility manager to discuss and monitor quality, safety and regulatory compliance. The PIC meets monthly with clinical management (DON, ADONs, CNMs) to discuss clinical governance. All previous inspection findings have been reviewed in relation to quality of assessments and care planning. All care plans have been reviewed and updated to reflect recent incidents or changes in resident conditions. Monthly audits are being conducted by ADONs on care planning records to ensure that they are completed in full and to ensure they are person centred. Feedback and corrective action plans will be developed for any areas that need improvement. All incidents, falls, complaints and concerns have been reviewed by the PIC from the start of 2025. All complainants have been contacted to ensure that they are satisfied with the measures taken to resolve the complaint. Any trends have been identified, and action plans have been put in place to ensure that there is organisation wide learning from the complaints received to improve levels of satisfaction with the service. Incidents and falls have been analysed to identify any specific risks. Trends have been identified, action plans put in place to address identified trends, and new initiatives implemented to reduce the risk of incidents and falls. This is being reviewed monthly in clinical governance and management meetings. All complaints and incidents are being reviewed monthly by the PIC with documented actions and follow ups. Regular updates are provided to families regarding improvements and actions taken. Residents receive updates during resident's meetings and through the meeting minutes. The DON participated in the Age-Friendly Health Systems initiative using the 4Ms framework to support an individualised, person-centred approach to care. ADONs now monitor peak periods (e.g. mornings, mealtimes) to ensure supervision is maintained. In the absence of ADONs, the DON or PIC is present to provide oversight seven days a week. This includes checking that allocated staff are present and are supporting residents to meet their individual needs at mealtimes and that safe and appropriate manual handling practices are being used.Fire safety training has been completed for staff following the inspection and ongoing training sessions are scheduled for October and November. Fire warden and fore Marshall courses are being provided for staff. All remedial works identified, and the following steps have been taken in relation to fire safety• Weekly checks continue to be carried out by External party.• Daily checks (Monday to Friday) carried out by Facilities Team.• Daily checks (weekends) carried out by Facilities and staff nominated form the accommodation team.• All Fire Safety maintenance caried out and up to date.• A Fire Safety Risk Assessment (external) has recently been carried out and we are working through the recommendations.• Numerous daily walk arounds carried out to ensure Fire Doors are not held open (where they should not be).• Utilising the HIQA Fire Safety Checklist (appendix 3) as part of our Monthly Maintenance Audits.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Complaints management system and policy was reviewed and updated by the PIC in August 2025 following the inspection. The HR department communicated policy with all staff by providing a copy of the policy and encouraged to read and understand it to ensure complaints procedure is followed correctly. The Registered Provider holds overall responsibility as the Review Officer for the complaints process. The Person in Charge is designated as the Complaints Officer. Staff training has commenced by the PIC to ensure that any complaints that are made, be they verbal or in writing are addressed at stage 1 and that the complainant is asked if the complaint has been resolved to their satisfaction. Staff are supported throughout the complaint management process by the ADONs to ensure they understand how to appropriately respond to complaints and are trained to document and escalate complaints to the Complaints Officer in a timely manner. Staff are educated on their responsibility to accept any complaints received, and wherever possible are empowered to resolve the complaint but should always inform it to the DON and/or Complaints Officer (PIC) at the time the complaint is made. All complainants have been contacted to ensure that they are satisfied with the measures taken to resolve the complaint. This includes any complaints made since the beginning of 2025.A record is maintained of whether the complaint is upheld fully or in part or not upheld. Any trends have been identified, and action plans have been put in place to ensure that there is organisation wide learning from the complaints received to improve levels of satisfaction with the service.PIC maintains record of complaints register and monthly reviews are scheduled with DON, ADONs and CNMs to discuss complaints. Key lessons and outcomes will be discussed at staff and management meetings. Regular monthly audits will be carried out by the PIC to identify patterns, ensure policy compliance, timely resolution and to propose service improvements. The registered provider will have direct oversight of complaints to ensure accountability and prevent recurrence of noncompliance.

Regulation 17: Premises	Substantially Compliant

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

All maintenance issued highlighted will be completed by the 30th September.
We have reorganized our storage areas and all hoists, mobility aids and specializes seating will be stored in appropriate storage locations by 15th September.
We have consulted with our occupational therapist and are sourcing appropriate grab rails from suppliers. We intend to have grab rails in all ensuites installed by the end of November.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

The PIC, DON and ADON have undertaken a review of resident care records, assessments and care plans with registered nurses. Areas for improvement have been identified, and there is a plan in place to address these areas with individual Nurses. Residents or their nominated representative have been involved in the review of the plan of care and their input has been recorded. Data from incidents and falls and identified clinical and other risks is being used to ensure that the plan of care for residents is individual, and that the residents are receiving rights based and person centred care and support. Ongoing review of assessments and care plans is being undertaken by the PIC, DON and ADON. Additional training on assessments and care plans has been sourced from external training providers.

Regulation 8: Protection	Not Compliant

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

Incidents and falls have been analysed to identify any specific risks in relation to protection. Trends have been identified, and action plans put in place to address identified trends, and new initiatives implemented to reduce the risk of incidents and falls. Any injuries that have been sustained that are unexplained have been specifically reviewed. Additional training in relation to safe manual handling practices and the protection of residents from injury is being completed. Refresher training on safeguarding and the protection of vulnerable adults is currently being carried out. This is being reviewed monthly in clinical governance and management meetings to ensure that measures are effective. Levels of compliance with training and policy are being monitored by the PIC, DON, ADON and registered provider

Regulation 9: Residents' rights	Substantially Compliant

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

Additional activity staff has been employed, and there are a variety of activities taking place on a daily basis across each floor, which are tailor made to suit the needs and wishes of residents. Feedback from residents regarding the activities has been sought to

ascertain their level of satisfaction with activities provided. There are additional staff employed to ensure that all residents are receiving activities in line with the abilities and preferences. Residents are always offered a choice of meals, and are able to change their choice if they wish. If they request a dish not on the menu, the catering team will endeavour to get this and prepare it fresh on the day for the resident. We acknowledge that there may be times when residents do not wish to have the meal they have chosen on the day, or do not like the recommended modified texture diet they have been prescribed. Staff have received additional training in relation to supporting the residents to exercise choice, to eat safely, and staff are providing additional support to residents at meal times to ensure they are assisted at the level needed to promote independence insofar as is possible. With additional staffing in place, residents can exercise choice in relation to the time they get up, go to bed and are supported with activities of daily living to meet their care needs. The minutes of resident meetings have been reviewed to identify if any issues have not been addressed. This has been discussed at subsequent resident meetings. For projects that require additional resources, or an external contractor to be employed, an action plan is in place to ensure that residents are aware of timelines for completion of these projects. Any issues that can be easily addressed are acted upon immediately and the individual resident is informed of the actions taken. This is then reported back at subsequent resident meetings and recorded in the minutes of the meeting. Each set of minutes has a copy of the action plan attached with specific timelines for completion of actions

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	19/08/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2025
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.	Substantially Compliant	Yellow	19/08/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Substantially Compliant	Yellow	19/08/2025

	be safe and accessible.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Red	30/06/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	30/06/2025
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	19/08/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response	Not Compliant	Orange	19/08/2025

	informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Not Compliant	Orange	19/08/2025
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Not Compliant	Orange	19/08/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are	Not Compliant	Orange	19/08/2025

	fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
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	30/09/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/09/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	18/08/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in	Substantially Compliant	Yellow	18/08/2025

	accordance with their interests and capacities.			
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	18/08/2025