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:	14 January 2026
Centre ID:	OSV-0005812
Fieldwork ID:	MON-0049342

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:	78

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 14 January 2026	09:15hrs to 18:20hrs	Una Fitzgerald	Lead
Wednesday 14 January 2026	09:15hrs to 18:20hrs	Fiona Cawley	Support
Wednesday 14 January 2026	09:15hrs to 18:20hrs	Helen Lindsey	Support

What residents told us and what inspectors observed

Residents living in Brampton Care and Rehabilitation Centre were complimentary of the staff, who provided them with care and support, in a caring and respectful manner. Residents spoke positively about staff as individuals who encouraged them to engage socially through activities and with other residents. However, some residents expressed discontent with some aspects of the service. For example, multiple residents were dissatisfied with the length of time it took the staff to answer their call bells, adding that often the bell is answered in order to stop the ringing tone, but the staff return at a later time to provide the assistance needed. Residents spoken with explained how there had been a significant change in the management of the centre, and in the staff delivering the direct care. Some residents voiced that they welcomed the changes, as they had noted some improvements with the engagement between the residents and the management team.

Inspectors arrived at the centre unannounced. An introductory meeting, was followed by a walk through the premises. Inspectors met with a number of residents during the walk around the centre, and spoke with a number of residents in detail about their experience of living in the centre. Some residents were unable to articulate their views on the quality of the service they received. Those residents appeared to be comfortable in the communal dayrooms throughout the day of inspection.

There was a busy atmosphere in the centre during the morning. Staff were observed attending to residents requests for assistance with their morning care in their bedrooms, and engaging with residents in a person-centred manner. Inspectors spoke with a number of residents in their bedrooms. Residents acknowledged how busy the staff were, and described how this impacted on the care they received. Residents repeatedly told inspectors about the high turnover in staffing. When asked how this impacted them, residents said that not all staff knew their needs. Residents described how they would wait for assistance. For example, one resident told inspectors that the 'staff are good but sometimes not enough staff', 'there was hardly any staff last week', and that 'response to the bell is variable'. Residents reported that, while the wait was unwelcome, staff acknowledged this wait when it occurred. Residents told inspectors that the staff were always rushing. When this was explored with the resident, inspectors were told that they felt staff could not give adequate time as they were rushing to meet the care needs of other residents who were also seeking assistance.

Throughout the day of inspection, residents were observed to be engaged in a variety of group activities. Some residents preferred to remain in their bedroom throughout the day. Multiple residents remained in communal rooms on the units. Residents were provided with opportunities to express their feedback about the quality of the service through scheduled resident meetings and through individual

conversations with the management. Visitors told inspectors that there had been many occasions when there has not been enough staff, and that they were concerned about the staff turnover, as they felt it negatively impacted on the residents. In addition, visitors voiced that they were not satisfied with the response to complaints raised. However, visitors echoed the voice of the residents in stating that they had noticed things have started to improve over the previous two weeks.

Residents were provided with information about the services available to support them. There was information about advocacy services displayed on notice boards, and in the lift, providing information to the residents and their families about contact arrangements. There was a short version of the complaints policy displayed on each floor of the centre, however, it named the complaints manager as a person not currently working in the centre. Residents and families who spoke with inspectors during the inspection said they knew who they could speak to if they had any concerns, and felt that the newly appointed nurse management team were both approachable and supportive.

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

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). Unsolicited information, submitted to the Chief Inspector in relation to adverse incidents involving residents, was also reviewed on this inspection. This information was substantiated on this inspection.

Overall, while residents reported recent improvements in the centre, this inspection found that the registered provider had failed to ensure that there were sufficient resources in place to effectively deliver care to residents. Additionally, the systems of management and oversight in place to monitor the management of complaints, incidents of safeguarding and the overall quality and safety of care to residents were not adequate. These deficits were found to potentially impact on residents' safety.

Brampton care Ltd is the registered provider of the centre. The chief executive officer (CEO) worked full time in the centre. The nursing management team as per the statement of purpose consisted of a person in charge supported by a director of nursing, two assistant directors of nursing, as well as a team of clinical nurse managers, nursing staff, health care assistants, administration staff, catering, housekeeping, activities staff and maintenance staff. At the time of the inspection a notification had been submitted to the Chief Inspector proposing a change to the person in charge. On the day of inspection, this proposed position was working in

the centre on a full-time basis and was supported in their role by two assistant directors of nursing (ADON), However, on the day of the inspection, the director of nursing hours were unfilled leaving a shortfall of 39 nurse management hours per week. Consequently, due to the changes in the structure, lines of responsibility and accountability were unclear. For example, the policy on the management of complaints, and the management of safeguarding concerns were the responsibility of the director of nursing, which as stated was vacant.

Inspectors found that the organisation and management of staffing resources was not effective, and that this adversely impacted on the quality of care delivered to residents. Staffing records demonstrated that the centre's staffing levels had recently been impacted by an increase in staff turnover. In response to this, ongoing recruitment was in place. Rosters reviewed evidenced a shortfall of up to 48 hours in one day in the healthcare assistant roles, who were responsible delivering direct care to residents. In addition, staffing rosters showed multiple days whereby the staffing compliment in the centre was reduced, with staff not replaced when they were unavailable to work. Feedback from residents and visitors supported the finding that residents were not always provided with assistance in a timely manner.

Records reviewed confirmed that training was provided through a combination of in-person and online formats. However, on the day of the inspection, the records were incomplete. The provider was unable to confirm the staff attendance at mandatory training such as fire safety, training in safeguarding residents from abuse, manual handling, and the management of caring for residents with complex care needs. Each staff member completed an induction process on commencement of working in the centre.

Some notifiable incidents, as detailed under Schedule 4 of the regulations, were not notified to the Chief Inspector of Social Services within the required time-frame. For example, inspectors found examples of complaints that detailed potential safeguarding concerns where there may have been a requirement to complete preliminary screening which was not identified and therefore, not managed through the centre's safeguarding systems, or notified to the Chief Inspector. In addition, inspectors found two examples of allegations of financial abuse where money had gone missing. Again, the incidents had not been recognised as potential safeguarding incidents and had not been notified to the Chief Inspector.

The management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner. This detail is outlined under Regulation 34: Complaints procedure.

A review of a sample of contract for residents found that they did not comply with the requirements of the regulation.

Inspectors reviewed a sample of staff files. The files contained the necessary information, as required by Schedule 2 of the regulations, including evidence of a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Regulation 15: Staffing

The number and skill mix of staff was not adequate to meet the needs of the residents, taking into account the size and layout of the designated centre. This was evidenced as follows:

- Multiple residents told inspectors that they were aware of the staffing shortages in the centre and felt that the staff were unfamiliar with their care needs, likes and dislikes.
- Key management hours were unfilled with insufficient deputising arrangements in place.
- Residents reported having to wait extended periods of time to have their call bell answered.
- Rosters evidenced multiple days whereby the staffing compliment was reduced, with staff not replaced when they were unexpectedly unavailable to work. The reduced hours varied from twelve hours, up to forty eight hours in a single day.

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 resulting in some records being inaccessible. For example, the provider could not confirm from the training records what staff had completed training in line with the requirements of the regulations.
- records of incidents with potential safeguarding implications, and complaints management were incomplete, resulting in information governance systems, essential for the quality and safety of the service, being ineffective.

This is a repeated finding from the last inspection in June 2025.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had failed to ensure that there were sufficient staffing resources in place to consistently maintain planned staffing levels, in line with the current resident care needs and the centre's statement of purpose. This impacted on the overall governance and oversight of the service. The service was dependent on the staff working additional hours, and to be available at short notice to support the rosters. In addition, this inspection found that the high turnover of staff was having a negative impact on residents' quality of life.

The registered provider had failed to ensure that there were effective governance and management systems in place to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- Where there was an identified safeguarding concern, preliminary screening had not been completed. In addition, other relevant documents for a number of open safeguarding investigations were not available to review.
- The system in place to ensure policies that guided practice were in place was not appropriate. For example; the two policies in place setting out the safeguarding arrangements were due for review in October 2025. However, this had not been completed. The policies set out key roles and responsibilities for the safeguarding process, many of which were associated with the director of nursing. However, there was no one in that post at the time of the inspection. The policy did not ensure processes were clear, roles and responsibilities aligned to the staffing structure.

The inspectors found that the provider had also failed to address outstanding non-compliances found on the last inspection of June 2025, in line with the provider's own time-line. This was in relation to, Regulation 23: Governance and management, Regulation 34: Complaints procedure, Regulation 21: Records, Regulation 5: Individual assessment and care plan and Regulation 8: Protection.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The registered provider had not agreed in writing, all the terms on which the resident would reside in the centre. For example, a number of contracts did not contain the following;

- The type of bedroom occupied by the resident
- The details of fees charged to the resident

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Inspectors found that the registered provider had received information about possible safeguarding incidents, and had not notified the chief inspector, as required by the regulations. For example; inspectors found two examples where money had gone missing. The incidents had not been recognised as potential safeguarding incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints policy was not in line with the requirements of regulation 34. While there was a policy in place that set out the roles and responsibilities of the complaints officer, and review officer, the policy did not set out the time lines for a review officer to respond with an outcome, should a review be requested.

A review of records, on a computerised system, recorded known areas of dissatisfaction with the service. However, the issues had not been recognised and recorded as complaints, and therefore the management team had not followed the process for investigation, as set out in the provider's complaints policy.

Judgment: Not compliant

Quality and safety

Inspectors found that, while the day-to-day needs of residents were met by staff, the continued failure of the provider to address significant non-compliance in the governance and management of the centre impacted on the quality and safety of the service provided to residents. This was particularly evident in the providers failure to take reasonable measures in the protection of residents, evidenced by the failure of staff to follow safeguarding processes in line with best practice, in recognising potential abuse, and responding appropriately when an allegation of abuse was brought to the attention of staff.

While staff who spoke with inspectors confirmed they had completed safeguarding training, records showed that staff were not consistently reporting incidents that should have been considered as safeguarding incidents correctly. An example was seen where a member of staff had reported an incident to their line manager, but the line manager had not the reported the issue to the person in charge. The

management team confirmed that they had noted, through their own review of practice, that staff knowledge of safeguarding approaches required improvement, and a face to face training programme was due to commence the week after the inspection.

Where safeguarding plans were required, they were seen to be basic, and did not set out the issues that had lead to the need for a plan, and the actions to be taken by staff to safeguard the individual and other residents.

Inspectors reviewed a sample of residents' care files. Following admission to the centre, a range of clinical assessments were carried out, using validated assessment tools, to identify areas of risk specific to each resident. These assessments were used to develop an individualised care plan for each resident, which addressed the residents' abilities and assessed needs. Inspectors found that the quality of assessments and care plans was inconsistent and did not always contain up-to-date information to guide staff to meet the needs of the residents.

Residents were reviewed by a medical practitioner, as required or requested. Referral systems were in place to ensure residents had timely access to health and social care professionals for additional professional expertise.

Friends and families were facilitated to visit residents, and the inspectors observed many visitors coming and going throughout the day.

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that they were not compliant with regulatory requirements. For example:

- A resident who was assessed as being at risk of malnutrition did not have an appropriate care plan in place.
- A resident with a specific medical diagnosis which may require timely responses from staff, did not have a detailed care plan in place to guide staff on what action to take.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GP) and the person in charge confirmed that GPs were visiting the centre, as required.

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

Judgment: Compliant

Regulation 8: Protection

Inspectors identified that reasonable measures to protect residents from abuse were not in place. While staff had completed training, there was evidence in the records reviewed that they were not identifying and reporting possible safeguarding incidents as they occurred. For example, the Chief Inspector had received reports of residents reporting poor care practices that increased the risk of injury. In the centre, these concerns, when raised by residents or their families, had been recorded as complaints, and so the management team had not followed their own policies in relation to managing incidents of suspected or alleged abuse.

Where safeguarding incidents had been managed through the correct process, the steps taken did not match the provider's policy, for example in relation to the investigations process. The steps set out in the policy described a team being appointed with allocated roles, but this had not occurred in practice. Some information requested by inspectors a number of times was not made available, which included the preliminary screening and other relevant documents for a number of open safeguarding investigations.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Brampton Care & Rehabilitation Centre OSV-0005812

Inspection ID: MON-0049342

Date of inspection: 14/01/2026

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
We have since initiated a robust and dynamic recruitment process, which has resulted in the recruitment of the following personnel: 5 nurses, .14 HCAs, and 1 ADON.

The following initiatives have also been implemented:
• Handover sheets are reviewed and updated daily by the Staff nurses and the Clinical Nurse Managers.
• HCAs' knowledge and understanding of residents' routines and needs are assessed daily using a specifically developed audit tool.
• Internal promotions have been completed to strengthen the management structure: two ADONs and two CNMs have been recruited internally. The DON role is currently covered by an Interim DON (30 hours/week).
• Two new Lead HCAs has been recruited for the rehabilitation unit.
• A call bell audit was conducted – 96% of calls were answered within the targeted time (within 5 minutes). Residents who use the call bell most frequently have been identified, and individual care plans are being developed to address their specific needs.
• The facility has access to three HCA agencies, and Brampton staff are also available to cover shifts as required.
• Management has initiated a review of the induction process, from recruitment (CV review and interviews) through to onboarding and role-specific induction.
• Staffing levels across all three units have been reviewed. The HCA ratio has been increased in the rehabilitation unit, and an additional CNM and two Lead HCAs have been recruited to support the management structure within the unit.
• Management is reviewing the contingency plan for various levels of staff shortages, based on the identified needs of residents in each care area.
• Monthly residents' meetings are in place, facilitated by the Person in Charge . The agenda includes staff communication with residents, upholding dignity and respect, and safeguarding concerns. Staffing levels will be added as a discussion point to seek resident feedback on this matter.
• An Employee Forum has been introduced to provide staff with the opportunity to share

their experiences while working in Brampton.
• An Employee Assistance Programme was introduced for staff in late February.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• The training matrix has been revised to reflect both individual training compliance and overall compliance
• A new system has been implemented to archive training certificates and sign-in sheets, which are now
readily available.
• We have now fully transitioned to recording complaints on a computerised system, with Stage 1 complaints documented within a single chart. All relevant documentation is completed, maintained by the PIC, and readily available.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Since the inspection, all relevant documentation relating to complaints management and safeguarding incidents has been completed and appropriately filed. A new filing system has been implemented. In addition, a new action tracker is being developed and will be introduced to ensure compliance with in-house policy.
• All safeguarding incidents are notified to HIQA and preliminary screening is completed in all cases.
• Key policies, including Safeguarding, Allegations of Abuse, and Complaints, have been reviewed, and reporting lines and responsibilities have been updated.
• Schedule 5 policies are currently under review and are being updated accordingly.
• The DON role is currently filled by an Interim DON working 30 hours per week. The Registered Provider meets with the clinical management team on a weekly basis.
• The Statement of Purpose (SOP) has been reviewed, and the organisational structure has been updated to reflect current arrangements

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Contracts were reviewed and appropriate appendix added outlining cost of care and associated charges. Type of bedroom to be occupied by the resident is now included in the contract of care

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All actual, suspected, or alleged safeguarding incidents are reported to HIQA within the required 2-day timeframe, irrespective of the stage of the investigation.
• Copies of all notifications are maintained in a designated folder in the PIC's office and are readily available.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The complaints policy has been reviewed and updated to reflect and improve current practice. Clear timeframes for acknowledgement and the investigation process are outlined.
• The PIC held a meeting with staff nurses and managers to discuss the updated complaints procedure and relevant documentation. Clarification was provided on how to distinguish complaints from safeguarding concerns

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

• A weight analysis was completed for all residents in February. This will now be carried out monthly to ensure that any changes in weight are identified early and appropriate preventative measures are implemented (e.g. dietitian review, MUST assessment, weekly weight monitoring, consideration of likes and dislikes, and family involvement to help identify residents' normal eating habits).

• The current care plan framework is under review and is being updated as required. The following care plan frameworks have already been introduced: anaemia, epilepsy, positive psychological support, community integration, and rehabilitation.

• A new care plan audit tool has been developed to include both health and social care needs.

• A specific staff knowledge assessment tool is being developed to ensure that staff are familiar with, and retain, knowledge of residents' individual needs and preferences, while also adhering to best care practice

Regulation 8: Protection	Not Compliant

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

• The safeguarding policy has been reviewed and updated. Reporting lines and lines of responsibility have been clarified, and the distinction between complaints and safeguarding incidents has been clearly defined. The policy is now aligned with current practice.

• Residents' meetings take place monthly and are facilitated by the Person in Charge . Safeguarding and the reporting of concerns are included on the agenda, and residents are encouraged to share their experiences. Management has received very positive feedback from residents on this initiative.

• Since the last inspection, the following meetings have taken place: two residents' meetings, an all-staff meeting, an HCA meeting, and a nurses' meeting. Safeguarding was discussed at each meeting, and, where relevant, lines of responsibility were clarified.

• Safeguarding training needs were analysed, and a series of in-house safeguarding training sessions were delivered in February and March (eight sessions in total). In addition, three full-day Dementia Care training sessions were completed during this period. These trainings were preceded by widespread education sessions for clinical staff, focusing on dignity in care, respect, and privacy. All staff received relevant educational materials.

• To further strengthen safeguarding practices within the facility, management will complete the HIQA Safeguarding Assessment – Judgement Framework for Designated Centres for Older People (V2.1 – 2025) and develop an action plan based on its findings.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/04/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	30/09/2026

	effective delivery of care in accordance with the statement of purpose.			
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	Orange	30/09/2026
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Not Compliant	Orange	30/09/2026
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	Orange	30/09/2026
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the	Substantially Compliant	Yellow	30/03/2026

	bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	30/03/2026
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	30/03/2026
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	30/03/2026

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	30/03/2026
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 fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	30/03/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/09/2026
Regulation 8(1)	The registered provider shall take all reasonable	Not Compliant	Orange	30/06/2026

	measures to protect residents from abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/06/2026