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:	Droimnin Nursing Home
Name of provider:	Droimnin Nursing Home Limited
Address of centre:	Brockley Park, Stradbally, Laois
Type of inspection:	Unannounced
Date of inspection:	08 April 2025
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0046795

About the designated centre

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

Droimnin Nursing Home is a designated centre for older people. The centre has one building that is purpose built. The centre provides accommodation for a maximum of 70 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence basis. The centre is located at the end of a short avenue in from the road and within walking distance to Stradbally, Co Laois. A variety of communal rooms are provided for residents' use including sitting, dining and recreational facilities. Each resident's dependency needs is assessed to ensure their care needs are met.The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, activity, administration, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	69

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 8 April 2025	08:30hrs to 16:50hrs	Sean Ryan	Lead
Tuesday 8 April 2025	08:30hrs to 16:50hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in Droimnin Nursing Home gave mixed feedback with regard to their lived experience in the centre. While many residents complimented the staff as kind and caring individuals, concerns were raised about the availability of staff and the timeliness of support with their care needs. Several residents expressed dissatisfaction with the provision of meaningful activities and the level of attentiveness from staff, which they attributed to staff being busy.

Inspectors were met by the person in charge on arrival at the centre. Following an opening meeting, inspectors walked through the centre, reviewed the premises and met with residents and staff.

During a walk around the centre, staff were observed busily attending to residents' morning care needs while simultaneously responding to other residents requests for assistance and answering call bells. One resident told inspectors that, although staff had come to assist them with their morning care, they were interrupted by another call bell and had to leave. The resident reported that the staff member had not yet returned, and that they were still waiting to get up. The resident added that they refrained from using their call bell in recognition of how busy staff were.

Another resident, who required assistance from multiple staff due to their care needs, was waiting for support with their personal care. While staff had checked in to ensure the resident was comfortable, the required numbers of staff were not available, at the time the resident wished to have their morning care. The resident emphasised that this was not the fault of any individual staff member, but rather a reflection of the overall staffing levels and availability.

Inspectors spent time speaking with residents in the communal dayroom areas, where staff were observed passing through intermittently to attend to residents in their bedrooms. However, some residents were in need of support, and staff were not readily available. In one instance, inspectors had to request that a staff member come to the ground floor communal area to assist a resident who required assistance. While staff were observed checking on residents in the first-floor communal areas in between their morning duties, those interactions were observed to be time-limited, and residents were observed to spend long periods of time with no social engagement or activity.

Throughout the morning, inspectors observed a number of residents being assisted by staff with their mobility care needs. Interactions were observed to be kind and person-centred, and it was evident that staff were familiar with the residents and understood their individual care needs well.

The premises was well-lit, warm and comfortably furnished, creating a welcoming and homely environment for residents. There was access to an enclosed garden that was appropriately maintained, featuring footpaths to support residents' mobility, as

well as seating areas. The garden appeared to be a pleasant and inviting space for residents to sit and enjoy.

Residents spoke positively about their bedroom accommodation, describing the rooms as comfortable, private and well-maintained. They expressed satisfaction with the space and layout, noting that their en-suite facilities were convenient and supported their independence. Several residents commented on how they appreciated having personal items and furnishings in their rooms, which helped create a homely and familiar atmosphere.

Inspectors observed the residents' dining experience and saw that staff were attentive to resident's needs throughout. Meals were attractively presented, and residents who remained in their bedrooms were served their meals on trays. Those who required assistance with their meals received support from staff in a respectful and dignified manner.

Inspectors observed a small group of residents participating in a chair-based exercise session at 11:30am. Residents appeared to enjoy the activity and the opportunity for social interaction with fellow residents and staff. However, residents on the ground floor were observed engaging in individual colouring activities, which did not promote social engagement. One resident told inspectors that, due to their physical limitations, they were unable to take part in chair exercises, and noted that no alternative activity had been offered to them other than colouring.

Some residents reported having the opportunity to participate in resident meetings and provide feedback about the service. While a number of residents were aware of the process for making a complaint, they were unclear about who specifically they should direct their complaint to. One resident expressed dissatisfaction with regard to a response they received in relation to their complaint.

The following sections of this report detail the findings in relation to the capacity and capability of the provider and describes how these arrangements support the quality and safety of the service provided to the 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).
- review the actions taken by the provider to address issues identified on the previous inspection of the centre in November 2024.
- review the quality improvement actions submitted by the provider in response to a provider assurance report request issued by the Chief inspector, following the receipt of unsolicited information.

The findings of this inspection were that the registered provider had not fully implemented or sustained a compliance plan submitted following the previous inspection of the centre, with regard to the governance and management of Droimnin Nursing Home. This inspection found that a poorly defined organisational structure, with unclear lines of authority and accountability, continued to have a negative impact on the the effective oversight of the service provided to residents. The provider did not ensure that appropriate systems of management were implemented to monitor the quality of care, and respond to risks that impacted on the safety and welfare of residents. This resulted in a deterioration in the quality and safety of the service. As a consequence of these concerns, an urgent compliance plan request was issued to the provider following this inspection. The plan submitted was accepted by the Chief Inspector.

Inspectors reviewed unsolicited information received by the Chief Inspector. The information received pertained to concerns regarding the governance and management of the centre, the quality of care provided to residents including social care, the supervision of staff and the management of complaints. This information was found to be fully substantiated on this inspection.

Droimnin Nursing Home Limited is the registered provider of Droimnin Nursing Home. It is a company consisting of three directors, one of whom represented the registered provider. The management structure supporting the designated centre had changed since the last inspection. A regional manager had been appointed and they were responsible for monitoring clinical and operational aspects of the service, in addition to providing support to the person in charge. However, inspectors found that while there was a sustained presence of the senior management in the centre, this was not found to have positively impacted the overall governance and management of the designated centre. Inspectors found a deterioration in the provider's oversight and accountability arrangements, resulting in inadequate monitoring and support for the service, and a failure to ensure safe, consistent and effective care.

Inspectors found that lines of accountability and authority were not clearly defined within the organisational structure. Within the centre, it was unclear who held responsibility for key aspects of the service such as the oversight and management of risk, safeguarding, and the management of complaints. The impact of this was inadequate and ineffective risk management systems, and systems to monitor and evaluate the quality of the service.

There were management systems, such as weekly key performance indicator reports, weekly and monthly clinical governance meetings and electronic auditing systems in place to identify, analyse and manage adverse incidents, and on-going risks in the centre. However, these systems were weakened by the inability of the management team within the centre to identify areas of poor practice, including ineffective supervision and allocation of staff, and the ineffective management of complaints and adverse incidents. For example, inspectors found incidents of safeguarding concerns that had not been identified and therefore had not been appropriately escalated to the senior management team. In addition, there was a lack of clarity within the centre regarding reporting structures to ensure that

incidents and risks were escalated to the senior management. This lack of reporting structures adversely impacted the provider's oversight and governance of the service.

Inspectors noted that the senior management team had proactively assessed the service and identified deficits in the governance and management prior to the inspection. However, the issues identified had not been resolved.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. While the provider had implemented a new system of electronic audits to evaluate clinical and environmental aspects of the service, the audit findings reviewed by inspectors did not identify issues of known risk in the centre. For example, a review of the complaints register found a number of recent complaints relating to residents waiting to have their call bells answered. However, a review of monthly call bell audits from January 2025 to April 2025 found 100% compliance in relation to call bell response times.There was no evidence that dissonance between these two issues had raised concerns about the findings of the call bell audit.

While there had been some action taken in the management of records since the previous inspection, particularly in terms of their availability and accessibility, the provider had still not fully complied with the requirements of Regulation 31, Records. As part of a compliance plan submitted by the provider following the last inspection of the centre, the provider had committed to ensuring that staff personnel files would be audited monthly to ensure that they contained all the requirements of Schedule 2 of the regulations. A review of staff files on this inspection found that the information remained incomplete. Furthermore, the directory of residents, reviewed on the day of inspection did not contain the detail in relation to any deceased or discharged residents, as required by Schedule 3 of the regulations.

Despite being identified on a previous inspection, the management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely manner. For example, A complaint received in January 2025 in relation to the care and treatment of a resident was not managed in line with the centres own policy or the requirements of the regulations.

Inspectors found that the supervision and communication systems in the centre between the nursing management and the care and support teams were ineffective. For example, care and support staff allocated to a resident with an acute infection, requiring infection control interventions including enhanced Personal Protective Equipment (PPE) requirements did not know what infection the resident had. This lack of direction and supervision of staff in relation to infection, prevention and control management posed a risk to the care and well-being of this resident and to all the residents in the centre.

On the day of inspection, inspectors found that the staffing levels and skill mix were not sufficient to meet the residents' overall needs, as some staff were frequently redeployed from their assigned roles. This impacted the delivery of key aspects of

care and support, including social and recreational activities. Inspectors observed residents experiencing prolonged waits for assistance with their morning care and being frequently left unsupervised in communal areas, where they were observed to be waiting for staff and assistance.

All staff were facilitated to attend training appropriate to their role, such as fire safety, safeguarding of vulnerable people, and infection prevention and control. this training. However, the provider had not assessed the effectiveness of all the training provided to staff and, as a result, had not determined if the training was adequate to meet the needs of residents and the requirements of the service. For example, although all staff had received fire safety training, there was a lack of clarity among staff regarding the evacuation needs of a resident with complex care needs, identifying potential gaps in the effective application of training to practice.

Inspectors found that staff were not adequately supervised to ensure residents' mobility care needs were met in accordance with their individual care plans. Furthermore, there was a lack of supervision in relation to the quality and accuracy of records maintained by staff.

Regulation 15: Staffing

The provider had failed to ensure that there were sufficient staffing levels in the centre to meet the assessed needs of the residents, or for the size and layout of the centre.

- Staff designated on the rosters to provide social care and recreational activities to all residents were reassigned to support physiotherapy and mobility plans for respite residents and assist with their implementation throughout the day. There was no alternative arrangements in place to ensure residents were provided with consistent activities. As a result, residents did not have access to meaningful social engagement or activity.
- Residents were observed waiting long periods of time for assistance with their personal care needs. Inspectors observed two occasions where staff were not available to support residents to get up from bed at a time of their choosing.
- Residents spoken with voiced their concern with regard to staffing levels. Residents reported, and were observed, waiting long periods of time to receive assistance with their care needs.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents. This was evidenced by the failure to;

- provide oversight of the resident's clinical documentation to ensure that resident's assessments and care plans were an accurate reflection of the residents care needs.
- ensure residents received social and personal care in line with their care plans.
- supervise and oversee the delivery of care and the implementation of recommendations of allied health care professionals.
- ensure nursing care records were appropriately maintained and reflected the care provided to residents on a daily basis.
- ensure staff are informed of residents care plans, including the detail of any acute infections.

Judgment: Not compliant

Regulation 21: Records

A review of the record management systems in the centre found that records were not managed in line with regulatory requirements. For example;

- Staff rosters did not reflect the staffing levels on the day of inspection and were not maintained in line with the requirements of Schedule(4)(9). For example, staff receiving induction were not included on the roster.
- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, one staff file did not contain two written references. Two staff files did not contain a full employment history, together with a satisfactory history of any gaps in employment.
- Nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that multiple nursing notes were duplicated from previous entries. This meant that the record was not person-centred and reflective of the care delivered to the resident.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that there was an effective management structure in place. The senior management structure responsible for the oversight of

the centre was not in place. There was a poorly defined organisational structure that impacted on the effective oversight of the service. Governance arrangements did not support the implementation of management systems to effectively monitor the quality of care, manage risks, or ensure timely escalation of issues that could impact on residents safety and welfare. The providers response to an urgent compliance plan request to address this risk did provide assurance that the risk was adequately addressed.

The registered provider had failed to ensure that management systems were effectively implemented to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- a failure to implement the centre's risk management systems to monitor and manage known risks with the potential to impact safety and welfare of residents living in the centre. Furthermore, the provider failed to implement the centre's safeguarding, and risk management policy to appropriately document and investigate a potential safeguarding incident.
- poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to nursing documentation, staff personnel files, and complaints.
- the auditing system in place to monitor the service did not identify known risks, such as infection control issues and resident waiting for care, and therefore, no risk management or quality improvement plan had been developed.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were not recorded and managed in line with the centres own policy and the requirements of the regulation. For example,

- A complaint received on behalf of a resident was logged in the complaints register, however, no investigation had been completed, and no follow up action was taken to address the complaint.
- A residents report of dissatisfaction with the service had not been documented and managed in line with the centre's complaints policy.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

The overall quality and safety of care was compromised due to ineffective governance and management, as detailed in the Capacity and Capability section of this report. Inspectors found that residents care needs were not appropriately assessed prior to their admission, which impacted on the care they received upon admission to the centre. Furthermore, care was not always provided to residents in line with their care plans or the recommendations of health and social care professionals. A request for an urgent compliance plan in relation to Regulation 5, Individual assessment and care plans was made by the Chief Inspector following this inspection.

Inspectors reviewed residents' assessments and care plans and found that, although all residents had a care plan in place, these plans were not always based on a comprehensive assessment of their care needs or reflective of their actual care needs. In addition, pre-admission assessments were found to be incomplete and did not adequately identify residents care needs or the supports, interventions and resources necessary to meet those needs safely or effectively. As a result, residents' mobility, social care and personal care needs were not consistently met and this impacted on their overall quality of life in the centre.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs. Residents could also access the expertise of health and social care professionals such as physiotherapists, occupational therapists, dietitian services and tissue viability nursing expertise. However, inspectors found that residents were not always referred for specialist input when clinically indicated, and recommendations made by health care professionals were not always implemented.

The procedure to safeguard residents was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents should a safeguarding concern arise. However, inspectors found that appropriate action had not been taken to investigate incidents or allegations of abuse, in line with the centre's own policy. In addition, where deficits in staff knowledge regarding safeguarding had been identified, reasonable measures had not taken to ensure that staff received appropriate training.

While there was an activity schedule in place, residents were not provided with activities in accordance with their interests and capacities. Inspectors found that there was an over reliance on activities that did not require assistance from staff or promote social engagement such as colouring, and staff rostered to provide activities were not consistently available to deliver a meaningful social activities programme.

Residents told inspectors that their rights were not always upheld, including limited choice around their daily routines such as when to get up from bed or to shower.

Residents were not always supervised in communal areas and call bells were not within reach for some residents, leaving them unable to request help when needed. This posed a risk to their safety and did not uphold their dignity.

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Pre-admission assessment were incomplete and failed to identify a residents complex care needs and the associated equipment resources necessary to safety meet their needs. This resulted in the necessary supportive equipment not being available to a resident for a period of seven days following their admission to the centre. Some equipment necessary to monitor their complex care needs was not in place of the day of inspection. The provider's response to an urgent compliance plan provided assurance that this risk was adequately addressed.
- Care plans were not guided by a comprehensive assessment of the residents care needs. Some resident's care plans did not accurately reflect the needs of the residents and did not identify interventions in place to support residents who had significant complex behavioural care and support needs. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of some residents who had experienced weight-loss had not been reviewed or updated following a change in their nutritional care needs. Consequently, their care plan did not reflect the nursing and medical interventions required to support their needs.

Judgment: Not compliant

Regulation 6: Health care

The registered provider failed to provide appropriate medical and health care including a high standard of evidence-based nursing care in accordance with professional guidance. This is evidenced by a failure to;

- provide a resident with timely and appropriate referral to health care professionals for further assessment and expertise when clinically indicated. For example, a resident who required support with a nutritional risk had not been referred for further expert assessment and review.
- ensure arrangements were in place to provide timely health care in line with the recommendations of health care professionals. For example, residents

who had been assessed by a physiotherapist did not have their mobility care plans implemented in line with their care plan.

Judgment: Not compliant

Regulation 8: Protection

The provider had not taken all reasonable measures to ensure residents were protected from the risk of abuse. This was evidenced by a failure to;

- identify and manage potential safeguarding incident reported to the nurse management team.
- to ensure that all staff had up to date training in Safeguarding management

This is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were not provided with adequate opportunities to participate in activities that reflected their individual capacities and preferences. On the day of the inspection, activity staff allocated on the roster to the provision of activities were seen assisting residents with their care needs, which limited their availability to deliver meaningful activities. Residents were observed spending long periods of time unsupervised, and there was limited social engagement taking place. Furthermore, a review of records of residents participation in activities confirmed that residents did not have consistent access to appropriate activities that enhanced their quality of life.

Residents' rights to exercise choice in relation to their daily routines was impacted by limitations in the availability of staff support. Some residents informed inspectors that they had to wait for staff assistance with their personal care needs and were therefore unable to leave their rooms until this support was provided. Other residents reported having to forgo a shower due to staff availability, indicating that their ability to make choices about their daily care routines was restricted.

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 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0046795

Date of inspection: 08/04/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

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

Outline how you are going to come into compliance with Regulation 15: Staffing:

To address the identified non-compliance under Regulation 15, the following actions have been implemented and are ongoing to ensure appropriate staffing levels that meet the assessed needs of residents, taking into account the size and layout of the centre:

1. Staffing Levels & Rostering
• A comprehensive review of current staffing levels has been completed, aligning rosters with both occupancy and resident dependency levels.
• Staffing complements have been revised to ensure adequate coverage across all key care functions: personal care, supervision, mobility, and social engagement.
• A Physiotherapy Assistant role has been introduced, with interim support in place on non-physiotherapy days. This role will provide consistent Monday–Friday coverage once recruitment is completed.
• The staff roster is reviewed daily by the PIC and ADON, with adjustments made based on current occupancy and care needs.
• A twice weekly staffing review meeting is now chaired by the PIC and ADON, with participation from the COO and HR Manager, focusing on dependency updates, staffing gaps, and recruitment progress.
• Recruitment efforts are actively underway. Two new HCAs have commenced, and three more HCA's and 1 RGN are in the onboarding pipeline.
• A recruitment tracker is maintained and reviewed weekly by the PIC and HR Manager to ensure timely induction and integration into the staffing schedule.

2. Social & Recreational Care Delivery
• Activity staff are now ringfenced and not reassigned to personal or physiotherapy care duties.
• A daily activities schedule has been reinstated to ensure residents have consistent and meaningful access to engagement.
• Monthly resident feedback is gathered through meetings and informal interactions to tailor activities to their interests and preferences.

• Resident satisfaction surveys regarding the timeliness of care and access to activities have been completed and reviewed. A quality improvement plan has since been developed and implemented based on the results.
• Residents' daily routines and personal preferences (e.g. waking times, hygiene choices) are currently being reviewed and documented within individual care plans. This process will be completed by June 20th.
• All staff are receiving refresher toolbox talks focused on supporting resident choice and ensuring timely care delivery. This training is scheduled for completion by June 13th.

3. Quality Assurance & Oversight
• Daily spot checks and informal audits are conducted to monitor real-time care delivery and staffing effectiveness.
• Any delays in care are now formally documented and addressed via the complaint management system to ensure continuous learning and improvement.

Regulation 16: Training and staff development	Not Compliant

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

To bring the centre into full compliance with Regulation 16, the following measures have been implemented and are currently in progress:

Daily Clinical Documentation Oversight
• The Management Team (PIC, ADON & CNM) now conduct a daily review of clinical documentation to ensure that care plans and assessments are accurate, timely, and reflective of residents' evolving needs.
• Any care plan not updated within 24 hours of a change in a resident's condition is highlighted to the responsible RGN for immediate revision. This process is designed to support reflective learning and reinforce accountability in timely documentation practices.

Care Delivery Monitoring
• The Management Team will perform structured daily walkabouts and spot checks on each unit.
• These checks confirm that personal and social care is delivered in accordance with resident care plans.
Resident feedback is actively sought through suggestion boxes, residents' meetings, satisfaction surveys, and an open-door policy. This ongoing engagement helps gauge satisfaction and informs continuous improvement in care delivery.

Improved Communication and Follow-up
• Weekly multidisciplinary team (MDT) onsite visits will include a follow-up report, which will be reviewed by the management team to monitor the timely implementation of

clinical recommendations.
• This report will then be shared with the nursing team to ensure all recommendations are clearly communicated, understood, and actioned appropriately.

Targeted Staff Training
• All nursing staff are undergoing refresher toolbox talks delivered by the Clinical Director and CNM scheduled for June 04th and 05th.
• Training content focuses on:
o Timely and accurate documentation
o Person-centred planning
o Recording interventions and changes in clinical condition

Audit and Oversight Measures
• Weekly documentation audits are completed by the PIC, with results reviewed and shared to the nursing team.
• In addition, full regulatory audits are conducted by the Senior Management Team to ensure independent oversight.
• Key findings are shared at morning handovers and reinforced in monthly staff meetings to sustain compliance awareness.
• Governance and Management meetings with both the Senior and Local Management Team are used to monitor progress, escalate non-compliance, and agree follow-up actions with clear accountability.

Regulation 21: Records	Not Compliant

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

To achieve full compliance with Regulation 21, the following measures have been implemented and are currently in progress:

Staff Rosters
• Rosters are now updated in real time to accurately reflect all staff on duty, including those in induction, training, or agency roles.
• A daily cross-verification process has been introduced to ensure roster accuracy against actual attendance.
• The PIC or ADON reviews and signs off on the previous day's roster each morning.

Staff Personnel Files
• A full audit of all staff files was completed by May 23rd.
• Any missing documentation (e.g., references, full employment histories with explanations for gaps) has been sourced and filed.
• A new HR compliance checklist is now mandatory for all new and existing staff files, signed off by the HR Manager and PIC before employment commences.
• Monthly spot audits of staff files are conducted by the Senior Management Team, with

results discussed at Governance and Management meetings.

Nursing Records
• All nursing staff are receiving refresher training on best practices in nursing documentation. This is scheduled for June 04th and 05th.
• Daily spot checks are in place to detect and prevent duplicate or copy-pasted entries.
• Identified non-compliance will result in formal performance reviews.

Monitoring and Oversight
• Monthly regulations audit now covers:
o Roster accuracy
o Personnel file compliance
o Nursing documentation standards
• Oversight is divided between the ADON (clinical and rosters) and the HR Manager/ Admin (personnel files).
• All findings are submitted to the RPR and reviewed during Governance & Management Meetings.

Regulation 23: Governance and management	Not Compliant

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

Strengthening of the Organisational Structure
• A revised organisational chart has been developed and disseminated to all staff, clearly defining lines of accountability and roles at both local and senior management levels.

Implementation of Management Systems
• Weekly Clinical Management Meetings continue to take place and are attended by the PIC, ADON, and Clinical Director. Key agenda items include:
o Risk register review
o Clinical KPI's
o Safeguarding concerns
o Complaint tracking
• Outcomes from these meetings are documented and tracked, which identifies accountable persons, deadlines, and progress updates.

Risk Management and Safeguarding Oversight
• The centre's risk management policy has been updated and re-circulated to all staff. Refresher training on risk identification, documentation, and escalation has been completed.

• A Risk Register is maintained and reviewed weekly by the PIC and Governance Team. Each identified risk includes controls, mitigation strategies, and action owners.
• Safeguarding concerns are discussed at weekly clinical meetings to ensure prompt escalation, documentation, and action, in line with national safeguarding protocols.

Record Oversight and Quality Monitoring
• Full audits of nursing documentation, staff personnel files, and complaints are underway.
• Monthly audit cycles are scheduled and assigned to specific members of the senior and local management teams.
• Audit results are cross-referenced with resident feedback and complaints to identify recurring themes or systemic issues.
• Where gaps are found, corrective actions are implemented immediately, and outcomes are tracked to closure. Findings from audits are monitored at Governance Meetings.

Escalation and Accountability
• A Compliance Dashboard and report has been introduced to capture performance across all regulations. The dashboard is reviewed monthly by members of the Senior Management Team.
• Escalation procedures are now formalised for any delay in implementation of actions, with automatic notification to the RPR if due dates are missed.

Monitoring and Timeframes
• Weekly Clinical Governance Meetings: Ongoing Weekly
• Risk Register and Safeguarding Review: Reviewed Weekly
• Monthly Audit Programme: In Place
• Compliance Report: First report submitted 30 March 2025, recurring monthly
• Performance Reviews for Non-Compliance: As required, ongoing

Regulation 34: Complaints procedure	Not Compliant

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

Complaint Recording and Investigation
• A full review of the complaints register is underway to ensure all complaints logged are accompanied by:
o Clear documentation of the investigation process
o Records of actions taken
o Date and method of communication of the outcome to the complainant
• All open or partially addressed complaints will be retrospectively reviewed, with follow-up actions completed and documented. This will be completed by June 13th.

Complaint Policy Reinforcement

• All staff have been reminded of the requirement to:
o Document all verbal and written complaints
o Escalate complaints to the PIC or designated person
o Manage complaints in line with the staged resolution process outlined in the policy
• A retraining session has been scheduled for the local Management Team on the Complaints Policy, including examples of verbal and informal complaints that require documentation. This will be completed by June 06th.

Complaints Monitoring & Governance
• The Senior Management Team will review the complaints register weekly to ensure full documentation and timely response.
• Complaints is a standing item on monthly Governance and Management meeting agendas.
• In addition, complaints are also discussed during each departmental meeting to ensure awareness, follow-up, and ongoing improvement across all teams.

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:

Pre-Admission Assessment Process
• The Pre-Admission Assessment Tool has been revised to include mandatory prompts for:
o Equipment needs
o Clinical complexity
o Communication or behavioural supports
• Admissions will now be approved only once the equipment availability and readiness checklist is completed by the PIC or ADON.

Comprehensive Assessment and Care Planning
• A full audit of existing care plans is underway to identify and rectify any gaps in assessment or linkage to care interventions.
• Each care plan will be reviewed to ensure:
o It is guided by a comprehensive assessment
o It includes clear, individualised interventions
o It addresses complex care needs, including behavioural support plans where applicable
o Any change in clinical condition (e.g. weight loss, behavioural change) will be reflected within 24 hours in the resident's care plan.
o This includes referral notes, clinical observations, and corresponding changes to interventions.
o This will be completed by June 20th.

Training and Education
• All nursing staff will undergo mandatory refresher training/toolbox talks on:
o Regulation 5 requirements
o Comprehensive assessment techniques
o Behavioural care planning and response documentation
• Training sessions are scheduled for June 04th and 05th.

Monitoring and Oversight
• Weekly audits of admission documentation and care plan reviews will be carried out by the Local and Senior Management Team.
• A monthly clinical documentation audit has been incorporated into the existing governance dashboard.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Timely Referral to Allied Health Professionals
• A full review of clinical escalation protocols has been undertaken to ensure timely referrals for residents with identified healthcare needs.
• An MDT referral report will be monitored daily by the nurse in charge, to track all referrals and ensure follow-up is actioned and recorded.
• Clinical staff have been instructed to escalate any delay in external appointments to the ADON/PIC within 24 hours for intervention.
• A nutritional screening protocol is being reissued to all nursing staff, reinforcing referral criteria to dietitian or SALT based on MUST scores or observed changes.

Implementation of Clinical Recommendations
• All care plans are now reviewed within 24 hours of receiving recommendations from allied health professionals to ensure updates are integrated.
• The MDT Communication Report on the centre's clinical system will be used to formally document all clinical recommendations and monitor their timely implementation.
• Daily handover sheets now include a 'clinical follow-up' section to verify that actions arising from allied health reviews have been implemented.
• Spot checks are being conducted by the Management Team to ensure that recommendations (e.g., mobility aids, exercises, dietary changes) are reflected in practice.

Training and Governance
• All nurses are receiving refresher training on:
o Timely referrals based on clinical indicators
o Care plan updates aligned with professional guidance
o Interdisciplinary communication best practices
• This is scheduled for June 04th and 05th.

• Clinical audit tools now include specific checks for:
o Timeliness of referrals
o Implementation of professional recommendations
o Evidence of resident outcomes and review

Monitoring and Oversight
• The ADON/CNM will conduct weekly audits of referrals and care plan updates with findings escalated to the PIC.
• Outcomes will be discussed at the monthly staff meetings to ensure sustained compliance and identify early detection of gaps with the nursing team.

Regulation 8: Protection	Substantially Compliant

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

Identification and Management of Safeguarding Concerns
• Immediate refresher training is underway to all members of the nurse management team on the identification, reporting, and documentation of safeguarding concerns in accordance with national policy and the Safeguarding Vulnerable Persons at Risk of Abuse policy. (Scheduled for completed by June 06th).
• A clear and mandatory escalation pathway has been developed and communicated to all staff. This includes defined timelines for internal reporting to the Person in Charge (PIC) and the designated safeguarding officer.
• All safeguarding concerns reported verbally must now be formally recorded in the Centre's Clinical Management System, with assigned review and follow-up dates to ensure accountability.
• A weekly safeguarding oversight review has been integrated into the standing clinical meeting between the Local Management Team and Clinical Director to ensure timely follow-up and appropriate action on all concerns raised.
• Safeguarding is now a standing agenda item at all staff meetings to reinforce awareness, encourage discussion, and promote a proactive safeguarding culture.

2. Safeguarding Training Compliance
• A full audit of staff safeguarding training compliance was completed. All staff members who were non-compliant will receive training and this will be completed by June 06th.
• Going forward, no new staff member will be placed on the roster until they have completed safeguarding training in full.
• Ongoing compliance will be managed via the training matrix, which is now subject to weekly review by both HR and the PIC to ensure real-time tracking and prompt intervention where required.

Regulation 9: Residents' rights	Not Compliant

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

Activity Provision
• A comprehensive review of the existing activity programme and related staffing resources has been completed.
• A dedicated activities coordinator is now allocated solely to the delivery of social and recreational activities and will not be assigned care duties during core activity hours.
• Weekly activity schedules are now displayed clearly in all units and are reviewed with residents during one-to-one and group discussions.
• Residents' "Key to Me" profiles are being updated to support more personalised and meaningful activity planning.
• Resident activity participation is now tracked using the centre's Clinical Management System to provide visibility and accountability.
• Resident satisfaction surveys will be carried out regularly to assess engagement and enjoyment of activities.

Resident Choice and Daily Routine
• Care plans are under review to ensure individual preferences such as wake/sleep times, bathing preferences, and dining choices are clearly documented and consistently respected. (Scheduled for completion June 20th)
• All staff are receiving refresher training focused on promoting resident autonomy, dignity, and the importance of respecting choice in daily routines. (Scheduled June 04th and 05th)
• A resident feedback mechanism is now active, allowing residents to report any delays or issues in real time, enabling prompt escalation and resolution.

Monitoring and Oversight
• Fortnightly reviews of the activity programme and resident engagement will be conducted by the Management Team and reviewed at Clinical Governance meetings.
• Resident satisfaction will be measured monthly through informal surveys and feedback during Residents' Council Meetings.

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	20/06/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	29/05/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	20/06/2025
Regulation 23(1)(b)	The registered provider shall	Not Compliant	Red	29/05/2025

	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.			
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	20/06/2025
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 fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	13/06/2025
Regulation 5(2)	The person in charge shall arrange a	Not Compliant	Red	20/06/2025

	comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
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	29/05/2025
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.	Substantially Compliant	Yellow	29/05/2025
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make	Not Compliant	Orange	13/06/2025

	available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	13/06/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	29/05/2025
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	06/06/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	29/05/2025
Regulation 9(2)(b)	The registered provider shall provide for residents	Not Compliant	Orange	13/06/2025

	opportunities to participate in activities in 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.	Not Compliant	Orange	20/06/2025