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:	07 September 2025
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0048168

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:	50

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
Sunday 7 September 2025	22:45hrs to 00:30hrs	Catherine Sweeney	Lead
Monday 8 September 2025	09:45hrs to 17:00hrs	Catherine Sweeney	Lead
Tuesday 16 September 2025	23:45hrs to 01:30hrs	Sean Ryan	Lead
Wednesday 17 September 2025	10:00hrs to 15:00hrs	Sean Ryan	Lead
Sunday 7 September 2025	22:45hrs to 00:30hrs	Sean Ryan	Support
Monday 8 September 2025	09:45hrs to 17:00hrs	Sean Ryan	Support
Tuesday 16 September 2025	23:45hrs to 01:30hrs	Catherine Sweeney	Support
Wednesday 17 September 2025	10:00hrs to 15:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Overall, residents living in Droimnin Nursing Home gave mixed feedback with regard to their experience of living in the centre. While residents were complimentary of staff, they described their daily routine as being inconsistent, and described waiting long periods of time to receive assistance from staff. Some residents also expressed dissatisfaction with aspects of the service, such as the quality of the food they received, engagement with management, and the support they received from some staff.

Inspectors arrived unannounced at the centre during the night time and were met by a nurse in charge. A brief meeting was held with nursing staff, during which the status of an ongoing COVID-19 outbreak was discussed. It was noted that staff were uncertain about the overall status of the outbreak. While staff were aware of the infection status within their own allocated floor and area of responsibility, they were unclear as to whether infection was present in other parts of the centre. Some staff were observed wearing personal protective equipment (PPE), including face masks, while others were not. One staff member were observed to not be complying with the registered providers uniform policy. Inspectors observed that, contrary to public health and infection prevention and control guidance, staff were moving between the ground and first floor.

Inspectors walked through the centre and spent time talking with residents and staff, observing the care provided to residents, and the care environment. It was observed that a number of residents remained in communal areas late at night, with some of these residents observed to be asleep in their chairs. Staff informed the inspectors that these residents did not go to bed until the early hours of the morning. During a walk-through the centre, inspectors asked one resident if they wished to go to bed. The resident confirmed that they did and this was communicated to staff, however, there was no immediate or appropriate response from the staff to the residents request for assistance. Only after inspectors intervened a second time did staff assist the resident to bed. This issue was again identified on the second night of inspection, when residents in communal areas were requesting assistance to go to bed, but staff, who reported being too busy, did not respond promptly resulting in residents waiting extended periods of time for assistance to go to bed.

Residents informed the inspectors that they could not access their bedroom on the first floor independently, even if they wished to do so, as the passenger lift was out of order. Although inspectors were told that the lift was only to be used in the case of emergencies, inspectors observed it being used frequently during the inspection, with some staff unaware that there was a fault with the passenger lift.

Inspectors observed that the allocation and supervision of staff was inadequate, particularly at night. On both nights of the inspection, residents in communal areas were unsupervised. Staff were observed attending to the care needs of other

residents in their bedrooms. During this time, some residents were calling out for assistance and requesting help directly from inspectors. On the second night, a vacancy in the health care assistant roster further reduced staffing levels, resulting in delays in supporting residents to go to bed at a time of their choosing. Residents expressed significant dissatisfaction with these delays, while also acknowledging that staff were very busy and that the situation was not intentional.

Inspectors observed that a large window in the first-floor communal area was wide open while a number of residents were present and unsupervised. Inspectors noted that the placement of furniture in close proximity to the open window was such that a resident with exit seeking behaviour would be able to access the open window. This presented a significant risk to residents.

On the days of inspection, inspectors met with residents who spoke about their experiences of the service they received. Residents spoke positively about staff who provided them with care and support, but also expressed concerns regarding changes in the staffing. Some residents reported that the dining experience was not enjoyable due to the level of noise, including loud music. In addition, residents described inconsistencies in the quality of the food they received. For example, one resident stated that the taste and presentations of meals alone indicated to them that someone inexperienced, or unfamiliar with the kitchen, was preparing their meals.

Residents also reported frequent changes to the management personnel in the centre and expressed uncertainty about who was in charge at any given time. They described this as a source of frustration, as when they sought clarification from staff, staff themselves were often unclear about who held responsibility and to whom residents' concerns should be directed. Inspectors observations and discussions with staff confirmed what residents had reported. Staff were also unsure as to who was in charge of the centre at the time.

The following sections of this report details the findings with regard to the capacity and management of the centre and how this supports the quality and safety of the service 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). This inspection took place over four days within a two-week period, due to significant and serious concerns regarding the safety and welfare of residents living in the centre. The registered provider had repeatedly failed to adhere to previous commitments to establish effective systems of governance and management and to ensure effective supervision of care practices.

As a result of serious concerns for the care and welfare of residents and in response to findings of consistently poor regulatory compliance over repeated inspections, in August 2025, the Chief Inspector of Social Services issued a notice of decision to attach a condition to the registration of the designated centre. The purpose of this condition was to stop new admissions to the centre until the Chief Inspector was satisfied that the provider had in place, an effective governance and management structure, and had achieved improved compliance with key regulations that underpinned the quality and safety of care provided to residents. The registered provider appealed this decision in the district court.

This inspection was carried out in response to information of concern about the care of residents that was received. Day one and day two of this inspection found a further significant deterioration in the care and well being of residents. As a result of the significant risk to the life, health and welfare of residents, on 12 September 2025, under Section 59 of the Health Act 2007, the Chief Inspector made an application to the district court to cancel the registration of the designated centre. A court date was scheduled for November 2025, and in the interim of that date two further days were added to this inspection.

This inspection found that the overall management of the centre was ineffective and that oversight of the quality and safety of the care provided to residents was poor. The impact of this was that a number of residents were consistently in receipt of sub-standard care. This failure of governance and leadership placed all residents living in the designated centre at significant risk to their welfare and safety. These risks were further compounded by an inconsistent organisational structure, with weak lines of accountability and responsibility resulting in a failure to monitor key aspects of the service, including clinical and nursing care delivery, nursing documentation, and quality monitoring.

Drominin Nursing Home Limited, a company consisting of three directors, is the registered provider of Drominin Nursing Home. The directors are also involved in the operation of a number of other designated centres for older persons located across the country. One of the company directors represents the registered provider in engagement with the Chief Inspector. The centre was supported by a senior management team consisting of management personnel with delegated responsibility for key aspects of the service including clinical and non-clinical operations.

Within the centre, the management structure was inconsistent and unclear. The registered provider had failed to appoint a person in charge since 31 July 2025. An assistant director of nursing assumed the role of director of nursing, leaving their substantive post vacant. A clinical nurse manager was in place to support the director of nursing. A group clinical director supported the nurse management team, and also deputised for the director of nursing when they were absent. This structure was found to create uncertainty, for staff and residents, as to who was actually in charge of the centre.

Over the course of this four day inspection, the management structure supporting the designated centre also changed. This included the redeployment of the group

clinical director away from the centre, followed by the appointment of a clinical and operations manager, and subsequently the appointment of a new regional manager. While the provider had increased the presence of senior managers in the centre, this increased presence did not ensure that that residents received safe, high-quality care, aligned to their assessed needs and care plans. These findings reflected concerns identified on previous inspections, indicating that the registered provider had failed to ensure that residents were in receipt of care appropriate to their needs.

The provider had repeatedly failed to implemented effective systems for the oversight and monitoring of the care provided to residents, particularly in relation to the implementation of recommendations from allied health care professionals and the monitoring of residents with complex medical conditions. Inspectors identified multiple examples where recommendations made by medical professionals were not implemented. This lack of supervision and oversight extended to critical aspects of residents health care, placing them at significant risk. For example, inspectors found that basic monitoring of a resident with a cardiac condition was not carried out in line with the recommendations of medical and health care professionals, despite the resident showing signs and symptoms of clinical deterioration.

The provider had implemented a program of night-time audits in July 2025, which identified deficits in the quality of care, including issues such as;

- poor medication management,
- reported delays in responding to residents requests for assistance,
- failure to assist residents with complex care needs with their night time care plans.

This inspection found similar deficits in the services. For example, inspectors were present on two nights and, on both occasions, observed residents either asleep in chairs in communal areas or requesting assistance to go to bed from staff, which was not provided. Medication administration errors were also identified. Despite these repeated issues being identified, no action had been taken to supervise the delivery of care at night.

Despite being identified on previous inspections, there remained ineffective oversight and implementation of the systems in place to manage risk and incidents. There was inadequate documentation of adverse incidents involving residents. Recorded incidents were poorly detailed and all the possible contributing factors had not been identified or considered. For example, one incident in which a resident sustained a serious injury had not been appropriately documented or reviewed by management. Furthermore, the incident record did not align with the information submitted to the Chief Inspector, nor with the nursing notes or the verbal account of the incident provided to inspectors. These inconsistencies had not been identified by the personnel responsible for the governance and oversight of the service who were in the centre at the time of the incident. This reflected on the registered provider's failure to identify, respond to, and manage risk in the centre, and maintain a safe and quality care environment for residents.

The provider had failed to establish and implement effective systems to communicate key clinical information to staff regarding residents' care. For example, inspectors reviewed the process for communicating residents' nutritional care needs to kitchen staff. During the course of this four day inspection, a system for communicating residents' nutritional care needs consisting of a dietary information sheet detailing residents individual requirements was established. However, inspectors found that this document was not updated and did not contain accurate information to ensure that residents consistently received nutrition in line with their assessed needs.

Similarly, a handover sheet to ensure that staff had access to up-to-date information and designed to guide daily care, had been developed and was in use. Staff confirmed that they relied on this document to inform them of residents' individual needs, including mobility care, wound care and personal care. However, inspectors found that the handover sheet also contained incorrect and inaccurate information, which posed a risk to the effective communication of residents' care needs. It could not be established who was responsible for ensuring that communication systems were effective and provided staff with accurate information to deliver safe, consistent and person-centred care.

This lack of oversight and supervision extended to the management and supervision of staff responsible for delivering care. Inspectors found that staff were not adequately supervised to ensure that care was provided in a safe, consistent, and effective manner. In the absence of appropriate direction and monitoring from management staff, care practices varied widely and critical elements of residents care were not implemented. Staff responsible for caring for residents with complex needs and pressure-related wounds were unaware that residents had such wounds, and therefore could not describe or implement the interventions prescribed by health care professionals to prevent and manage them. This was compounded by a lack of awareness, on the part of those responsible for the supervision of residents care, as to whether prescribed interventions had been carried out or implemented. These findings demonstrated a repeated failure by the provider to establish and implement systems to ensure that essential health care interventions were consistently delivered in line with professional recommendations.

The provider had failed to ensure the effective management of records, and there were ongoing issues and continued non-compliance with the requirements of the regulations. In particular, the system used to record staff rostering and attendance was not effective, which impacted on the organisation and management of staffing resources. This issue had been repeatedly highlighted in inspection findings since November 2024, yet remained unaddressed. Inspectors found that the provider had failed to ensure there was an appropriate standard of record-keeping in relation to the care and treatment provided to residents particularly in relation to the documentation of adverse incidents.

Regulation 14: Persons in charge

The registered provider had failed to ensure that there was a person in charge of the centre.

Judgment: Not compliant

Regulation 15: Staffing

The registered 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. For example;

- Residents spoken with reported having to wait a long time for care to be delivered. Inspectors observed that, during night time, health care staff were carrying out kitchen duties, at a time when the service was short health care staff. Residents reported, and were observed, waiting long periods of time to receive assistance and support from staff to go to bed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The registered provider failed to ensure that staff were appropriately supervised to carry out their duties to protect and promote the care and welfare of residents. This was evidenced by the failure to supervise;

- the accuracy of nursing care records, including assessments and care plans and adverse incidents. A review of clinical documentation found inconsistencies, inaccuracies and omissions that were not identified by the nursing management.
- the delivery of care to residents, in line with their assessed needs and care plans. For example, residents at risk of malnutrition and who had experienced significant weight-loss, were not provided with nutritional care in line with their care plans. The nurse management team were not aware that the communication system between the care and catering team was ineffective.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

The provider failed to ensure that the management of records was in line with the requirements of the regulations.

- The nursing record for residents' health and treatment given, following an incident in which a resident suffered harm was incomplete and inaccurate. There was no documented assurance that appropriate assessment, treatment and care was delivered to a resident following a serious incident.
- 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 nursing notes were duplicated from previous entries over a seven day period. This meant that the record was not person-centred, and did not provide assurance that the daily care needs of the residents had been met.
- Records did not demonstrate that residents had received care in accordance with their assessed needs and care plans, or that appropriate interventions were implemented as required.
- The staff roster was inaccurate across the four days of this inspection. This is a repeated finding from previous inspections.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. In particular, there was a failure to ensure that staffing resources and the management structure were organised to support the safe and consistent oversight of care. The provider had also failed to ensure the service had sufficient staffing resources to;

- ensure the management structure was maintained in line with the centre's statement of purpose. This impacted on effective governance and oversight of the service.
- maintain adequate clinical nurse manager staff levels to ensure effective support and supervision of the nursing and health care staff teams.

A weak and undefined organisation structure contributed to the provider failing to address, or take appropriate action, following the significant high risk findings of the previous inspection of the centre. This resulted in repeated non-compliance with the regulations assessed. The roles and responsibilities of the management team were poorly defined. For example, accountability, responsibility and oversight of key aspects of the service such as the management of risk, monitoring of residents' nutritional care needs, the oversight of clinical care records, and the provision of health care to residents were not clear, and resulted in poor outcomes for residents.

The registered provider had failed to ensure there were effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. Inspectors found repeated failings in the governance arrangements that included;

- Ineffective systems to ensure key clinical information regarding residents care needs were effectively communicated to staff. Staff did not have access to accurate information about residents' individual medical and nursing care needs, which significantly impacted the quality and safety of care provided.
- Ineffective systems in place to monitor and promote the well-being of residents through timely and appropriate referral to medical and health care services, and implementing the recommendations of health care professionals.
- Poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to medication management, nursing documentation, and incidents were found to be poorly recorded.
- Poor oversight of the incident management system and incidents involving residents. There was no evidence that serious incidents, including the unexpected death of a resident or a serious injury, had been appropriately recorded or investigated. In addition, incidents relating to medication omissions that had been brought to the attention of the management team, were not documented or investigated.
- Ineffective auditing systems. For example, nutritional audits did not include an analysis of the findings, and areas for learning had not been identified. Therefore, there was no quality improvement plan developed to ensure residents' nutritional care needs, and nutritional risks were appropriately identified, monitored, and managed
- Poor oversight of nursing documentation. A review of the quality of residents' care plans found that care plans were not based on the assessment of residents needs or risks. Care plans, particularly those relating to residents at risk of malnutrition, impaired skin integrity, and complex medical care needs, were not based on assessment and did not reflect the current care needs of the residents. Therefore, care plans lacked the required detail to ensure residents received safe and effective person-centred care.
- Repeated non-compliance across all regulations reviewed on this inspection.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

Over the course of this four-day inspection, it was evident that the failings in the governance and management arrangements, as outlined in the Capacity and

Capability section of this report, had a significant impact on the quality and safety of the care provided to residents. This inspection identified serious and repeated deficiencies in care delivery, particularly in relation to the provision of health care to residents and the failure to ensure that individual assessments and care plans accurately reflected residents' needs. Furthermore, care plans were not consistently accessible to staff to provide appropriate guidance on the delivery of safe and person-centred care.

Residents' individual assessments and care plans were reviewed over the course of this inspection. While each resident had a care plan in place, these did not accurately reflect residents' assessed or actual care needs, or their complex health conditions. As a result, care plans did not contain the required information to guide staff on the delivery of appropriate care to residents. Furthermore, inspectors reviewed multiple records where it had been documented that residents had ''refused care''. However, there was no evidence that these refusals had been reviewed or followed up by the management team in the context of residents assessed needs or to ensure that care was being delivered in a way that respected residents' choices and preferences. For example, staff told inspectors that a resident exhibited responsive behaviours at bedtime, which was the reason the resident was left in communal areas late at night. However, the residents' assessments and care plan did not describe any such behaviours, nor did they indicate any disturbances in sleep or concerns regarding their sleep pattern. In addition, care plans were not always reviewed or updated when a resident's condition changed or deteriorated, further impacting on the effectiveness of the care plan in supporting safe and person-centred care. Consequently, the provider had failed to ensure that residents' needs were consistently and appropriately met.

Despite the provider's assurance, through compliance plans, that effective systems had been established to monitor resident's health care needs, this inspection again identified significant and persistent non-compliance with the requirements of the regulations. A review of residents nursing and medical notes found that, while residents were provided with access to general practitioner services and other health care professionals for specialist assessment, the recommendations made by these professionals were not always implemented. This failure was found to significantly compromise the quality and effectiveness of care provided to residents.

Furthermore, residents who showed signs and symptoms of clinical deterioration did not consistently receive safe, evidenced-based nursing care, and the provider failed to ensure that a high standard of such care was delivered.

A review of the nutritional aspects of the service was undertaken during this inspection, in light of concerns previously identified in relation to the nutritional care of residents. Inspectors found that the provider had repeatedly failed to establish and implement systems to identify clinical nutritional risk and monitor the nutritional care needs of residents. Inspectors reviewed the care of residents assessed as being at high risk of malnutrition. While these residents had been referred to the dietitian and specific recommendations were made to manage their weight loss, these recommendations were not implemented. Inspectors found that staff who were responsible for preparing residents meals, were unaware of residents weight loss

and nutritional risks. Furthermore, staff had not been provided with the necessary information about residents individual nutritional needs, such as the requirement for diabetic diets or fortified meals. As a result of these failings, inspectors found that, residents for whom dietetic recommendations had not been implemented, continued to lose weight.

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, this inspection found that the provider had failed to effectively implement policies and procedures designed to safeguard and protect residents.

Regulation 18: Food and nutrition

There was a failure to deliver food and nutrition to residents in line with regulatory requirements. This was evidenced by;

- Residents' dietary needs were not consistently met, as prescribed by health care professionals. Several residents were prescribed therapeutic diets, tailored to their specific medical conditions, such as renal or diabetic diets, did not receive meals in line with their assessed needs. In addition, residents who were at risk of choking or had impaired swallowing and were prescribed modified-consistency diets did not consistently receive meals in accordance with these prescriptions. This placed those residents at significant risk of harm. Furthermore, this information was not communicated to, or known by, the staff responsible for preparing residents' meals or by those providing nutritional care.
- The food provided to residents was not wholesome and nutritious, nor did it reflect the prescriptions of health care professionals. Residents assessed as requiring high-protein, high-calorie diets, to support the management of their weight were not provided with meals that met these essential nutritional requirements.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The registered provider had failed to take effective action to comply with the requirements of this regulation. For example;

- Care plans were not informed by a comprehensive assessment of the residents care needs and, in practice, did not reflect residents actual care

needs. Residents were observed sleeping in chairs in communal areas or calling staff for assistance to go to bed at night, despite their care plans specifying that they should be assisted to bed and highlighting the importance of restful sleep. The care provided to residents was contradictory to the residents' care plans, and not reflective of their care needs.
- Care plans were not reviewed or updated when a resident's condition changed. For example, a care plan to support a resident's increased monitoring of their chronic health condition was not reviewed or updated following their return from the hospital. As a result, staff did not have the necessary information within the care plan to guide the clinical care, monitoring, and interventions required to meet the resident's needs.
- Where care plans were developed, the registered provider failed to ensure that residents received care in line with their assessed needs and care plans. The care plan for a resident with a pressure ulcer outlined specific interventions required to prevent further deterioration and promote wound healing. However, these interventions had not been implemented.

This is a repeated non-compliance.

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;

- ensure arrangements were in place to appropriately monitor a resident following discharge from the acute health care services. Specific recommendations for the ongoing monitoring of a resident's complex health care needs had been outlined by medical professionals. However, these recommendations were not implemented including monitoring of their cardiac condition for deterioration, and appropriate systems were not in place to provide timely and evidence-based health care, in line with best practice.
- implement the recommendations of medical professionals regarding the completion of diagnostic blood tests for residents with deteriorating health in a timely manner. In some cases, diagnostic blood and urine tests requested for residents whose health was deteriorating were either delayed or not carried out.
- ensure residents had timely access to health care professionals for further expert assessment and appropriate treatment to support the management of their pressure ulcers. For example, a residents had not been referred for expert assessment for equipment necessary to prevent deterioration of a pressure ulcer.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse. This was evidenced by a failure to;

- appropriately document and investigate incidents of potential abuse and safeguarding concerns. The provider was made aware of several care incidents that were indicative of potential safeguarding issues. However, these incidents were not recognised as safeguarding concerns and were neither documented or investigated in line with the centre's safeguarding policies and procedures.
- Safeguarding plans intended to protect residents from the risk of abuse were not effectively implemented. Measures, such as enhanced supervision of residents with complex behavioural needs, were not effective to safeguard and protect the resident and others. This resulted in repeated incidents occurring.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider failed to ensure that residents' rights were upheld within the centre.

- Residents were restricted in exercising choice in relation to aspects of their daily lives, such as the time they went to bed. Inadequate staffing levels to provide supervision and support meant that residents were not consistently facilitated to go to bed at a time of their choosing.
- Residents continued to express concern about the lack of information provided to them regarding changes to the management structure and were unsure as to who was actually in charge of the centre. They had not been consulted or informed in relation to changes in the designated centre.

This is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0048168

Date of inspection: 17/09/2025

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A new PIC commenced fulltime employment in the center on 28/10/2025 The PIC is a registered nurse and has the required experience of nursing older persons to meet Regulation 14 requirements. The PIC is employed on a full-time basis and will work over a 5 day period The PIC will undergo induction and complete all mandatory training in line with training and development policy.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A full review of the roster across all departments is underway. The director of Payroll and Rosters from PPIM Curam Care Homes has governance responsibility to ensure rosters are completed and published and available to all staff in the home. A review of daily allocations is underway, to ensure that clinical staff are available to attend resident care and not be deployed to other departments. All residents are undergoing a full clinical reassessment of dependency and careplan review to ensure a 24hour rights based approach careplan is in place. Care plan meetings will be held with residents and their family (as directed by resident) and communication of careplan updates provided to all staff.	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A training and development plan will be completed for each member of staff. This plan will be developed by firstly auditing compliance with mandatory training completed to date and any noncompliance identified will be addressed by the provision of appropriate training.
In addition to mandatory training a "best practice" training list as set by PPIM to include rights based approach to healthcare and dementia awareness training for all staff.
Following completion of training – training validation assessments will be completed by PPIM clinical staff to capture staff across all departments. Any shortcomings from staff identified in the validation process will result in a referral to the PIC for communication sheet and appropriate action plan.

The PIC has reviewed rosters and allocations for ADON, CNM and head of departments in conjunction with PPIM Director of Payroll and Rosters to ensure provision of appropriate supervision of all staff.
There is a clinical member of the PPIM onsite 7 days a week for at least 7.5 hours.
The recruitment campaign for a second CNM is ongoing.
A daily huddle / handover document and procedure has been implemented daily at 3pm and is led by ADON Monday to Friday and by PPIM Clinical Lead at weekends. The huddle is attended by all department staff.

The Clinical Staff from PPIM review resident KPI's daily and set and oversee completion of actions. Each incident, complaint, concern and safeguarding screening is reviewed daily to ensure staff compliance with local policy on actions assigned to staff and reviewed if required.

All staff will be rostered to attend in person Safeguarding training, Dementia awareness training, Manual and Patient Handling training from the Training and Development Officer.

All staff will have to complete rights-based approach to healthcare training online.

All nursing staff will receive in person Resident Assessment and Care plan training from the Training and Development officer.
Focused careplans will be added for those residents identified at risk of malnutrition, risk of falls, with pressure area's or with behavioral signs and symptoms of dementia.
All resident weights and MUST scores are reviewed weekly by PPIM clinical staff. All residents have had a dietary needs assessment completed and this information has been shared with catering staff who are supported now 3 days a week by PPIM Catering Manager.
Resident specific recommendations from MDT SALT and Dietition has been shared with catering staff. Supervision to ensure provision of food and fluids in line with MDT recommendations is completed by PPIM Catering Manager.

A dietitian review identified as high risk residents is scheduled to take place on 4th December. Following on from the review all recommendations will be updated in resident careplan, shared with catering and clinical staff and implementation supervised by PPIM clinical lead daily.

A new weekly reporting structure into PPIM will ensure that all resident incidents, concerns, complaints, clinical KPI's and Safeguarding issues are reviewed fully by PPIM and weekly action plan assigned to the PIC for completion.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A new weekly reporting structure into PPIM will ensure that all resident incidents, concerns, complaints, clinical KPI's and Safeguarding issues are reviewed fully by PPIM and weekly action plan assigned to the PIC for completion.

All nursing staff will attend in person documentation and care planning training. Our electronic nursing record will allow us to identify any member of nursing staff found to be duplicating nursing entries from previous days. This member of staff will then be managed in line with HR policy and procedure.

All HCA's to have training on documenting on the electronic touch care system.

The PIC is responsible for ensuring that the resident careplan is based on their assessed needs. The PIC, ADON, CNM and PPIM Clinical lead will supervise the provision of daily care to the residents in accordance to their careplan. Guidance and feedback will be provided daily to staff on duty. Any staff member who fails to provide appropriate care to a resident as outlined in the care plan and in accordance to resident preference will be managed inline with company HR procedure.

A full review of the roster across all departments is underway.
The director of Payroll and Rosters from PPIM Curam Care Homes has governance responsibility to ensure rosters are completed and published and available to all staff in the home. Each department head will then have responsibility to ensure any changes are captured on the roster each day to ensure the roster accurately reflects the staff on duty. The PIC has responsibility for verifying the accuracy and completeness of rosters and for supervision of staff.

The registered provider is responsible for ensuring that all records required under regulation 21 are kept in the designated center. An audit of all records required under regulation 21 will be completed and a SMART action plan developed to manage any issued identified with the accuracy and completeness of these records.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A new organizational structure is now in place with the addition of Curam Care Homes as PPIM.
A roster is available in the home containing the PPIM presence in the home across the following departments:
Operational, Clinical, Catering, Activities and Housekeeping / Laundry.
The PPIM undertake accountability and responsibility for the oversight of management of risk, monitoring of residents nutritional care needs, the oversight of clinical care records and the provision of healthcare.
The PPIM provides Clinical Oversight to the home via Director of Care, Quality & Standards, Director of Risk and Compliance and a Training and Development Officer.

Operational Oversight to the home is provided via Chief Operations Officer, Chief Executive Officer, Director of Payroll and Administration, Director of Finance and HR.

A fulltime PIC is employed in the center and this PIC reports directly to the PPIM in line with the updated organizational structure.
A Fulltime ADON is employed in the center.
A fulltime CNM is employed in the center and a recruitment campaign for a second CNM is ongoing.

Representation from PPIM senior managers from Activities and Catering and Housekeeping and Laundry have been deployed and are providing departmental supervision and oversight 3 days per week.

From 1st December a new clinical lead will be employed fulltime on the home and working over a 7 day / night period as directed by PPIM.
The roles and responsibilities of each of the above positions are clearly set out.

The PPIM Management Team will provide daily onsite support and supervision to guide and oversee the PIC and nurse management team as well as Head of Departments by attending handovers and daily huddles, supervising mealtimes and spot checking medication rounds, reviewing resident KPI's, Monitoring resident appearance and wellbeing, food and fluid charts, touch care reports and being available to meet residents and family. Reviewing concerns and complaints.

A general staff meeting with PPIM and PIC has been scheduled for Thursday 27th November and following this, separate departmental meetings will begin. An agenda, minutes and action plan will be available.

A resident and family meeting with PPIM and PIC has been scheduled for Thursday 27th November. An agenda, minutes and action plan will be available.

A review of the Dietetic Company SLA has been completed, and a meeting took place between the company rep and dietitian and PIC and PPIM to confirm process for referrals, reviews and implementation of MDT recommendations to resident care plans.
All residents with risk of malnutrition have been reviewed by the dietitian, all residents with skin integrity issues have been reviewed by the TVN, all residents where concerns arose in relation to appropriate IDDSI due to dysphagia have been reviewed by SALT and recommendations are being overseen daily by PPIM clinical Lead.
• A full reassessment of each resident will be completed. All staff will have access to person centered careplan on the homes electronic record system.
• Introduction of a resident assessment, care plan and documentation audit with clear SMART action plan.
• Review of handover procedure and documentation will be completed.
• Introduction of daily resident occupancy checklist for nursing staff to complete and handover each shift.
• Full weekly review of incidents to ensure appropriate escalation to investigation process.
• Implementation of dining experience observational tools and SMART action plans.
The addition of PPIM head chef to plan and implement the QIP required for ensuring nutritional risks are appropriately identified, monitored and managed.
Meeting arranged with home management, PPIM and Nutritional Dietetic Company to review SLA and organize training, review menu's and dining experience.
• Addition of focused careplan framework to electronic record system to address the deficits in careplanning for those residents at risk of malnutrition, impaired skin integrity, and complex medical care needs.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Each resident will be reassessed for risk of malnutrition.
Where required new referrals to SALT and Dietitian will be completed.
Residents under care of SALT or Dietitian with prescribed care will have a focused careplan commenced.
Focused care plans will be shared with all catering and care staff.
All residents to have a Diet notification form completed and shared with catering staff.

A training needs analysis will be completed for all catering staff and specific training in IDDSI, provision of specific diets such as renal, diabetic, high protein, high calorie.

The provision of Catering Manager from PPIM to oversee Food and Nutrition QIP.

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:
A comprehensive reassessment of each resident will take place,

Addition of focused careplan framework to electronic record system to address the deficits in careplanning for those residents at risk of malnutrition, impaired skin integrity, Positive behaviour support and risk of falls.

Each careplan will be reviewed in conjunction with the resident and their family (as appropriate) to ensure it is person centered, rights based and informs and directs staff how to care for the resident in line with resident wishes, will and preference.

All nurses to complete in person training with training and development officer on care planning, assessment and documentation. Care plans will be reviewed formally by the PIC as a full aduit on each careplan will be completed every 4 months.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
On readmission from hospital a full reassessment of residents will now be undertaken. A weekly audit of admissions / transfers will identify any gaps in recommendations not being implemented and a SMART action plan put in place.

The ADON / CNM are rostered and allocated to manage the weekly GP round and will document in resident file and follow up on any diagnostic tests requested.

A review of SLA's with Dietetic company is underway and meeting arranged. Referrals made for all residents with wounds to be reviewed by TVN and at risk malnutrition by Dietitian.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All reports of care incidents that are indicative of potential safeguarding issue will be screened within 3 days on Preliminary Screening Document on electronic record system safeguarding module and reported to Director of Care, Quality and Standards. Where indicated an NF06 will be submitted.

All staff to receive in person Safeguarding training, Safeguarding training validation spot checks will then be rolled out by training and development officer.

Designated officer training to be completed by PIC, ADON and CNM.

Safeguarding plans intended to protect residents from risk of abuse will be appropriate to the needs and wishes of the resident and will be added into focused careplan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A person-centered rights based approach care plan will be developed for each resident and this care plan will outline the resident wishes in relation to how they choose to spend their day in the home. The daily roster review and allocation sheet will ensure that appropriate clinical staff are available to assist residents with care that their chosen time.

Correspondence will be sent to all residents and families to inform them of recent changes to organizational structure. A new communications platform for families will be initiated similar to the system used by the PPIM in their centres. A resident's and family meeting is scheduled for the 27th November 2025.

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 14(1)(a)	The registered provider shall ensure that the designated centre has a person in charge.	Not Compliant	Orange	11/11/2025
Regulation 14(5)	Where the registered provider is not the person in charge, he or she shall ensure that the documents specified in Schedule 2 are provided by the person concerned.	Not Compliant	Orange	11/11/2025
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/11/2025

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	21/11/2025
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Not Compliant	Orange	05/12/2025
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	12/12/2025
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	31/12/2025
Regulation 23(1)(a)	The registered provider shall	Not Compliant	Orange	12/11/2025

	ensure that the designated centre has sufficient resources to ensure the 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	11/11/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	21/11/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	08/12/2025
Regulation 5(2)	The person in charge shall	Not Compliant	Orange	08/12/2025

	arrange a 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.	Not Compliant	Orange	14/11/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/01/2026
Regulation 6(1)	The registered provider shall, having regard to	Not Compliant	Orange	30/11/2025

	the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Orange	21/11/2025
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	12/12/2025
Regulation 8(1)	The registered provider shall take all reasonable	Not Compliant	Orange	17/12/2025

	measures to protect residents from abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	14/11/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	21/11/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	27/11/2025