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:	Kilcoole Lodge Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Lott Lane, Kilcoole, Wicklow
Type of inspection:	Unannounced
Date of inspection:	27 July 2026
Centre ID:	OSV-0007714
Fieldwork ID:	MON-0051171

About the designated centre

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

Kilcoole Lodge Nursing Home is situated in the village of Kilcoole and is in walking distance of the sea. It is a purpose-built facility which can accommodate a maximum of 89 residents over two floors in 81 single en-suite rooms and 4 twin en-suite rooms. It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care for persons with learning, physical and psychological needs can also be met within the unit. Care is provided for people with a range of needs: low, medium, high and maximum dependency. The registered provider is Mowlam Healthcare Services Unlimited. The person in charge of the centre works full time and is support by a senior management team and a team of healthcare professionals and care and support staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	86

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 27 July 2026	06:05hrs to 15:55hrs	Sarah Armstrong	Lead
Monday 27 July 2026	06:05hrs to 15:55hrs	Laurena Guinan	Support

What residents told us and what inspectors observed

Overall, the inspectors found that following the previous inspection, the registered provider had implemented actions to drive improvements in the centre. These improvements included enhanced governance and management oversight systems, improved staffing skill mix, greater supervision of staff practices and a revised assessment and care planning programme for all residents.

Feedback received about the service from residents, visitors and staff was all positive, with some individuals commenting on recent improvements that they had noticed, such as the cleanliness of the premises and reduction in noise associated with the call-bell system. Residents who spoke with the inspectors said that there were improvements in staff response times when they required assistance. One resident said "they're quite good, they're usually down to me very quickly now" and another told inspectors, "anything I want they get for me, the staff are very good". Another resident said "it used to be that you could be waiting quite a while, but it has gotten much better lately. I don't have to wait as long now". On the day of inspection, inspectors observed the staff to be responsive to residents' requests for assistance and although call-bells were heard ringing during the day, the inspectors found that they were not ringing as frequently as was noted on previous inspections, which had resulted in a calmer and more peaceful atmosphere in the centre on this occasion. The inspectors also saw a high level of supervision of residents in all communal spaces, and staff were seen and heard to actively engage in a meaningful manner with those residents they were supervising.

This was an unannounced, partially out-of-hours inspection. The inspectors arrived at the centre at 06:05am, as previous inspection findings had identified a lack of oversight and supervision in the centre during the night shift, which had an impact on the quality of care provided to residents. On arrival at the centre, the inspectors met with the designated nurse in charge on the night shift, before they commenced a walkabout of the premises. The general atmosphere in the centre was calm and relaxed. During the walkabout, the inspectors observed a number of bedroom curtains were open on both floors, which meant these rooms were bright from early in the morning, and residents on the ground floor could be seen in their beds from the outside. This had been observed on a previous inspection, but none of the bedrooms on the path from the car park to the main entrance were impacted on this occasion. The residents in these rooms were all asleep in bed. This was discussed with the nurse on duty who said that residents had requested the curtains remain open to allow fresh air from open windows to circulate during the period of hot weather. The inspectors spoke with some residents in these rooms later in the day and they confirmed that they had requested this. However, it was unclear whether residents unable to verbalise had requested this measure. This was also discussed at the feedback meeting, and the health care manager informed the inspectors that

privacy screenings were sourced for bedroom windows and due to be installed in August 2026.

Kilcoole Lodge Nursing Home is a purpose-built centre spread over two floors with resident accommodation on each floor. There was a sitting room, dining room and visitors' room on each floor, as well as toilet and shower rooms, sluices, and store rooms. Residents also had access to a hairdressers' salon, oratory and coffee dock on the ground floor, and an activity room on the first floor. Many residents had personalised their bedrooms with photographs, cushions and throws, and communal areas had soft furnishings and pictures that gave a homely feel to the centre. On previous inspections, the oratory had been used as an office and store room. The inspectors saw that the room was now available for it's intended purpose, and there was evidence that residents and their families had been informed of this.

Inspectors observed the morning staff handover (the process of transferring duties, tasks, and vital information from one employee or shift team to another) on both floors of the designated centre. Staff were provided with written handover sheets, and verbal handover from the night staff gave a comprehensive report on residents' changing needs during the night. All direct care staff were seen to be present for the full report, and a clinical nurse manager also attended the handover on each floor.

After the walkabout, the inspectors met with the Healthcare Manager and the acting assistant director of nursing (AADON) and an introductory meeting was held where the purpose of the inspection was set out. The person in charge was on leave on the day of the inspection, and the Healthcare Manager was deputising in their absence.

Staff who spoke with inspectors also provided positive feedback and described recent improvements they had observed. One staff member said "there's definite improvements. We have loads of stock now, we have everything we need". Staff also referenced that members of the management team were present in the centre regularly, and complimented the approach of management to engage with staff and seek feedback on the service. One staff member said "management are coming to us and they are asking us how things can be improved, and how can things be done better for the residents".

The inspectors saw that all areas of the centre were kept clean and tidy, and residents' records were stored securely at the nurses' stations. Corridors were free of obstruction and had handrails so that residents could mobilise safely throughout the centre. Feedback from residents and visitors referenced improvements in the cleanliness of the centre. One visitor told the inspectors "we've noticed things are cleaner than they had been, we've definitely seen improvements. There was a big problem with ants before, but that is much improved now". Visitors also told inspectors that they were generally happy with the care their relative was receiving and that the staff were kind and approachable. One visitor said "everything here is fine, there's no problems. If there ever is anything, I can just say it to the staff and there's no issue, they sort it out."

Breakfast was seen to be mostly served to residents in their bedrooms, with a small number of residents on the first floor using the dining room. Most residents were seen to dine in the dining rooms at lunch time. The inspectors were told that residents were always given a choice where to have their meals, and most preferred to have breakfast in bed, but enjoyed the social aspect of the dining room for other meals. There was ample staff to assist residents at meal-times, and residents spoken with said that there was a good choice of food available, and the food was tasty. On the day of inspection, residents were served vegetable soup, followed by a choice of roast beef or loin of pork with apple sauce, vegetables, mash and roast potatoes. There was a choice of dessert also, which included fresh fruit salad, or rice pudding.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This inspection was conducted following receipt of a representation from the registered provider in response to a notice of proposed decision to stop admissions to the designated centre, until such time that the registered provider demonstrated to the Chief Inspector of Social Services improvements in compliance with specific regulations, and had implemented a revised governance and management structure. The registered provider had a recent history of poor compliance with the regulations, with significant non-compliances identified during two previous inspections of the centre on 19 March 2026 and 8 June 2026. This partially out-of-hours risk-based inspection was conducted to assess if the provider had implemented measures to improve regulatory compliance, as committed to in their representation, and to ensure the safety and welfare of residents living in the centre.

The inspectors found that, while the registered provider had taken actions to address issues identified on inspection in March and June 2026, oversight in the areas of maintenance of the premises, referrals to allied health professionals, and addressing issues raised by residents was not always sufficiently robust to ensure a high standard of delivery of care.

The registered provider of Kilcoole Lodge Nursing Home was Mowlam Healthcare Services Unlimited. There was a person in charge who worked full-time in the centre. They were supported by an assistant director of nursing and a team of clinical nurse managers. Staff nurses, health care assistants, activities coordinators, household, catering and maintenance staff made up the remainder of the staff team in the centre. The inspectors reviewed staff rosters and saw that they were in line with staffing on the day. An assistant director of nursing had been recruited to fill an existing vacancy, and they were due to commence employment in the coming

months. In the interim, a clinical nurse manager had been appointed as acting assistant director of nursing. The health care manager gave assurances that on the next staff roster, three remaining clinical nurse manager positions would be allocated supernumerary status, with two on duty each day and one to be rostered on duty until 10pm, four times per week. These measures were already partially implemented and aimed to improve management support to the person in charge, and to enhance staff supervision. The health care manager and the quality and compliance coordinator had also committed to being on site a minimum of two days each per week to provide a total of minimum four days management support to the person in charge, and this was seen to be in place.

The inspectors reviewed call-bell audits completed since the last inspection, and these reflected what was seen on inspection. Call-bell audits showed that response times had improved. Two audits documented a delayed response, and action was taken immediately to identify and address the reason for the delay. An action plan to address issues identified in a falls prevention audit had been completed, with improvements made to assessments and care plans post-fall. The registered provider had also developed a new care plan template and this was being introduced, to include a full reassessment, for all residents.

The registered provider had committed to conducting daily management walk arounds to provide oversight of staffing, provision of care, and the maintenance of the premises. The inspectors saw records of checklists completed during these walk arounds, with actions required being completed. The standard of cleanliness had improved, and one staff had been identified as an Infection Prevention and Control (IPC) link person. A second IPC link was being sourced from the staff team. A pest control company had been engaged to manage the presence of ants and silverfish infestations. This was seen to be under control on the day of the inspection, and positive progress made to address the matter was also commented on by residents and visitors.

On review of nursing records, a residents' sensor alarm was documented as either not being in place or not working on five occasions since the 9th of July. Maintenance records showed that this had been reported twice. It was unclear from the documentation whether the sensor alarm had been repaired or replaced, and staff were not clear on the procedures to follow if a maintenance issue reoccurred. While the resident's sensor mat was in place and working on the day of inspection, this issue was brought to the attention of management who committed to reviewing the maintenance log system with staff.

There was a schedule of management, staff and residents' meetings that showed two-way communication in the centre. Issues identified from inspections, audits or management walk arounds were seen to be communicated to staff. For example, the use of induction checklists for agency staff was discussed, and nurses were reminded to secure nurses' stations where residents' records were kept. There were regular residents' meetings that were well-attended. However, there was no action plan to address requests made by residents during meetings in April and July. The health care manager confirmed that one of the the requests had been actioned, but

this was not evident from the meeting minutes. This will be discussed under Regulation 23: Governance and management.

The inspectors saw that there was a good supply of personal hygiene and personal protective equipment in the centre. Staff spoken with told the inspectors that they knew where these supplies were stored, and they said there was now an adequate supply available at all times, for use by staff and residents.

Inspectors reviewed the incident log in the centre and found that all incidents that required notification to the Chief Inspector had been submitted within the required timeframe. There was an enhanced oversight system in place in the centre to review incidents and complaints which was supporting prompt, appropriate management of the incidents, including notification to the Chief Inspector of Social Services.

The inspectors reviewed the training matrix and saw that there was a suite of training available to staff. However, a number of staff had not received up-to-date training in fire prevention. This had been identified during an internal review of the matrix, and the inspectors were shown that a schedule of training sessions to address this had already commenced. Safeguarding workshops that had been committed to in the urgent compliance plan had also taken place, with two further workshops scheduled for August and September this year.

Induction checklists for agency staff had been implemented, and agency staff working on the day of the inspection had completed these. Comprehensive induction processes for new staff, that were tailored to specific roles, had been introduced. Staff who had recently finished their induction period said that they felt supported during the process, and confirmed that they were mentored and supervised by senior staff. Induction checklists were seen to have been monitored by a clinical nurse manager. Performance improvement plans were in place where necessary, and these were seen to have recommendations, such as enhanced supervision and training, implemented with good effect.

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill mix to ensure that residents' needs were met in a prompt manner.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to training appropriate to their role, and that staff were adequately supervised.

Judgment: Compliant

Regulation 21: Records

Records maintained in the centre were kept in such a manner as to be safe and accessible.

Judgment: Compliant

Regulation 23: Governance and management

While the management systems ensured that residents were safe, the systems in place had not always ensured that the service provided was effectively monitored. For example:

- The oversight of the maintenance of the premises was not sufficiently robust to ensure that there was a system in place to facilitate the prompt reporting of issues with residents' equipment.
- The oversight arrangements in place did not ensure that residents requests were effectively monitored, followed up and addressed in a timely manner.
- The oversight of referrals to allied health professionals was not sufficiently robust to ensure that all referrals were made in a timely manner, and were completed in a comprehensive manner.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Improved oversight systems had been introduced to ensure that incidents requiring notification to the Chief Inspector were submitted within the required time frame.

Judgment: Compliant

Quality and safety

Overall, a number of improvements to the quality and safety of resident care were found on this inspection and residents, relatives and staff all spoke of their improved experience of living, visiting and working in the centre. However, the inspectors found that further improvements were required to ensure that residents received appropriate reviews by health and social care professionals in response to their care needs.

The inspectors reviewed a sample of residents' care plans including washing and dressing, elimination, maintaining respect and dignity, skin integrity, end of life and discharge plan, communication and sleeping care plans. This review showed that whilst all care plans had been updated within the required time frames, some care plans contained historical information, for example, historical information about wounds which was no longer relevant to residents' current care needs. This did not support staff in providing appropriate care to residents and is discussed in more detail under Regulation 5: Individual assessment and care planning. However, the registered provider had developed a new system to ensure that residents had their needs appropriately and comprehensively assessed. This system included a complete reassessment of each residents' needs, to ensure appropriate referrals to other health and social care professionals were made, and that care interventions were appropriate and aligned to each residents' needs and preference. As part of this piece of work, the provider had put in place measures to ensure that care plans were created and appropriately reviewed and revised by clinical staff, to ensure that they contained person-centred, current and suitably detailed information to support staff in providing good quality care to residents. There was evidence available to inspectors on the day that this new assessment and care planning approach had been implemented in practice for some residents, using a risk-based approach.

Whilst some improvements were noted by inspectors in respect of appropriate referrals being made to other health and social care professionals, further improvements were required to ensure that residents received appropriate reviews and care interventions following a referral. For example, there was evidence of prompt referrals being made to tissue viability nurses, but there were gaps identified in the oversight of the service being provided to ensure that the resident experienced a good clinical outcome. Treatment plans for residents' wounds were not always clear, as the photograph included in the online review made it difficult to correctly assess the stage of the wound. In one case, despite continued deterioration of the residents' wound, there were no efforts made by the registered provider to organise an onsite review of the wound by an appropriate healthcare professional. These findings are set out under Regulation 6: Healthcare.

Improvements were noted in respect of the systems in place to ensure that residents in the centre were appropriately protected from abuse. Staff had completed training in safeguarding vulnerable adults and the registered provider had organised a number of safeguarding workshops for staff to further promote learning in this area. Where allegations of abuse were made, the inspectors saw evidence that appropriate investigation into the matter was carried out by the person in charge, with outcomes and learnings identified and communicated with staff.

Residents who spoke with the inspectors said that the staff were gentle and that they felt safe living in the centre.

Efforts had been made by the registered provider to promote residents' rights in the centre. The oratory which had previously been unavailable for residents use and had previously been unknown to residents, had been redecorated and reserved for use by residents as they now wished. There was evidence that the availability of the oratory had been communicated to residents, and residents who spoke with inspectors were aware of the oratory and where it was located in the centre. At the time of the inspection, the provider was considering ways to further promote the use of this space, for example, by setting up a residents' prayer group.

The registered provider had also made improvements to promote residents' privacy in the centre through the planned installation of privacy screens on external windows. There was evidence presented to inspectors that this work had been approved for completion and was due to be carried out by contractors in August 2026. Residents were seen taking part in a range of activities on the day of inspection and information about upcoming resident outings was displayed on notice boards, including a guided tour of Kildruddery House on 04 August and a trip to the National Concert Hall on 17 August. Residents who spoke with inspectors knew how to find out what activities and events were taking place in the centre. Reflective practice meetings were taking place between the healthcare manager and all staff nurses in the centre during July and August, with some having been completed at the time of inspection. As part of these meetings, resident choice was featured as an agenda item and staff were being reminded and offered an opportunity to discuss the importance of promoting residents' choices in their care journeys. Residents who spoke with inspectors said they could choose the times they wished to get up and go to bed, what to eat and where to dine for their meals.

Regulation 5: Individual assessment and care plan

Inspectors found that although residents' care plans had been reviewed within the time frames committed to by the provider, they had not always been updated to remove historical and conflicting information about their current care needs. This did not inform staff of the appropriate, person-centred care needs of the resident concerned. For example;

- One resident's skin integrity care plan described their skin as "currently intact", however this resident had a current pressure injury and the details of this wound and care interventions were included later within their care plan.
- One resident with a diagnosis of diabetes and a weight management issue did not have their diagnosis included in their care plan, nor was there an appropriate dietitian review carried out for this resident to inform their food and nutrition care plan. In addition, the catering department was unaware of the resident's diagnosis and their dietary needs.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider did not always ensure that residents were provided with access to appropriate medical and healthcare. For example;

- Despite a timely referral to an appropriate health care professional, one resident who had a deteriorating wound was seen to have only received off-site reviews of their wound using photographs. Responses from the healthcare professional referenced an inability to determine the grade of the wound from the provided photograph and as a result, was unable to provide an appropriate recommendation for treatment. The registered provider had not followed up to request an in-person review for the resident to identify an appropriate treatment pathway.
- One resident with a diagnosis of diabetes and weight management issues was unable to proceed with a dietitian review due to having no weight recorded. Although this resident had been referred for a dietitian assessment, and a dietitian had visited on site, inspectors were informed that this review did not take place as planned due to there being no recorded body weight measurement.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken reasonable measures to protect residents from abuse. Staff had received training in relation to the detection and prevention of, and responses to abuse. Where an allegation or incident of abuse had arisen, the person in charge had investigated the matter.

Judgment: Compliant

Regulation 9: Residents' rights

There were suitable facilities for occupation and recreation. The registered provider had ensured that residents had opportunities to participate in activities which were in accordance with their interests and capacities. Residents also had access to radio, television and internet and were supported to access independent advocacy services as required. Residents' were supported to exercise choice in their daily lives.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kilcoole Lodge Nursing Home OSV-0007714

Inspection ID: MON-0051171

Date of inspection: 27/07/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

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

• The Person in Charge (PIC) will be supported by the Healthcare Manager (HCM) in the achievement of all objectives and safe, effective operation of the centre.
• The Quality & Compliance Coordinator (QCC) will provide additional support to the management team in assessing compliance, implementing quality improvement plans and evaluating the progress of the plans.
• The Director of Care Services will attend regular governance meetings with the centre's management team, HCM and QCC to assess progress and to ensure effective oversight of restoration of regulatory compliance in the centre.
• Routine and low-level maintenance in the centre is provided by a maintenance person employed through an external Facilities contractor. The company has assigned a regional supervisor/Facilities Engineer to provide oversight. The maintenance person will be accountable to the Person in Charge (PIC) for day-to-day routine work. Priorities will be agreed with the PIC or deputy, and the PIC will direct routine maintenance requests locally. The regional supervisor will oversee the maintenance person's performance to ensure that all routine tasks are completed within the agreed timeframe.
• The PIC will oversee that all maintenance requests are logged on the tracking system. Each request will be assigned a priority level according to its urgency and its impact on residents. The PIC will review all open maintenance and resident requests weekly. In addition, the Facilities Management Team and external contractor partners will conduct a weekly facilities review of all requests to monitor progress and ensure timely completion.
• The PIC will communicate with designated allied healthcare professionals to the Centre, such as Tissue Viability Nurses, to stipulate the requirement for onsite reviews. Oversight will be maintained by the PIC and CNM to ensure that this obligation is maintained appropriately.

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

• The PIC will ensure that residents' care plans are person-centred and developed in consultation with the resident and/or their nominated representative.
• For those residents with actual/potential skin integrity issues and nutritional concerns, the PIC and CNM will ensure that appropriate assessments are carried out to identify the level of risk, and that an individualized skin integrity and Nutritional care plan will be developed to ensure that the care interventions are adequately outlined and addressed.
• The PIC and CNM will complete a review of care plans, and all historical information will be archived. Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings. Any changes or developments in the resident's condition or plan of care will be updated as they occur.
• The CNM will provide a report to the catering department on residents' diagnosis and dietary needs at time of admission and again where changes in condition or dietary needs occur. Communication will be maintained with all staff at daily handover and mid-shift daily safety pause meetings.

Regulation 6: Health care	Substantially Compliant

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

• The PIC will communicate with designated healthcare professionals to the Centre, such as Tissue Viability Nurses, to stipulate the requirement for them to undertake onsite assessments and reviews.
• Oversight will be maintained by the PIC and CNM to ensure that this obligation is maintained appropriately.
• A wound care review will be completed, and a robust SMART Quality Improvement plan will be developed based on any identified actions. Oversight of this QIP and actions taken will be maintained by the PIC.
• A weekly review of MDT referrals will be completed by the PIC, with oversight maintained, to ensure all appropriate actions are implemented and to ensure that there are no delays in referrals and assessments.
• Where weekly weights are indicated, oversight will be maintained by the PIC and CNM, ensuring early identification of any resident at risk of malnutrition and appropriate intervention and escalation to the GP and/or Dietitian or Speech & Language Therapist (SALT).
The PIC and CNM will provide weekly oversight of appropriate assessment and referral to ensure that all healthcare needs of each individual resident are consistently met.

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 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.	Substantially Compliant	Yellow	31/12/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/12/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not	Substantially Compliant	Yellow	31/12/2026

	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.			
Regulation 6(1)	The registered provider shall, having regard to 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.	Substantially Compliant	Yellow	31/12/2026
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.	Substantially Compliant	Yellow	31/12/2026