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

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| Name of designated centre: | Clondalkin Lodge Residential Home |
| Name of provider: | Bartra Op Co (Clondalkin NH Pres) Limited |
| Address of centre: | New Road, Clondalkin, Dublin 22 |
| Type of inspection: | Unannounced |
| Date of inspection: | 06 March 2025 |
| Centre ID: | OSV-0008600 |
| Fieldwork ID: | MON-0046527 |

## About the designated centre

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

Clondalkin Lodge Residential Home is located in the centre of Clondalkin Village, with the convenience of the M7 and M50 motorways, and is close to a variety of shops and restaurants. The centre can accommodate 147 residents, male and female over the age of 18 years. There are 145 single bedrooms, and one twin bedrooms, all of which are en suite. Clondalkin Lodge Residential Home aims to provide a person-centred, caring, and safe alternative for older persons with varied care needs in a professional and empathetic manner.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 146 |

## 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 |
|---|---|---|---|
| Thursday 6 March 2025 | 08:15hrs to 16:30hrs | Karen McMahon | Lead |
| Thursday 6 March 2025 | 08:15hrs to 16:30hrs | Aoife Byrne | Support |
| Thursday 6 March 2025 | 08:15hrs to 16:30hrs | Sharon Boyle | Support |

## What residents told us and what inspectors observed

This inspection took place in Clondalkin Lodge Nursing Home. During this inspection, the inspectors spent time observing and speaking to residents, visitors and staff. The overall feedback the inspectors received from residents was that they were happy living in the centre, with particular positive feedback attributed to the staff team, food and premises. Residents were observed to be content and relaxed throughout the inspection day. Overall the observations on the day of the inspection were that staff provided assistance to residents in a caring and compassionate manner.

After a brief introductory meeting, the inspectors walked through the premises accompanied by the person in charge. The centre was split over four floors, with 145 single occupancy bedrooms and one twin bedroom. All bedrooms had ensuite facilities. Residents' bedrooms were observed to be bright, spacious and comfortable. Many residents had personalised their rooms with photographs and personal possessions from home. All the rooms had a cosy and homely feel to them and were unique to each of the residents residing in them.

There was a choice of communal spaces located across all floors of the centre. Each floor had access to at least a dining room and sitting room. There was also a visitors room and physio therapy room located in the centre. The centre was tastefully decorated with photographs of familiar landscapes of Dublin such as Dun Laoghaire Pier, Poolbeg chimneys and Killiney beach. Photographs of residents enjoying different activities were also displayed throughout the centre, with residents enjoying trips to the garden centre and attending a Christmas party.

Residents had access to two outdoor enclosed spaces. These spaces were observed to be well maintained and had suitable pathways for residents who use mobility aids. There was suitable outdoor furniture. There was a designated smoking area located outside which had appropriate fire safety equipment and call bell facilities. However, not all residents could freely access these areas due to the placement of keycode locks on the doors and lifts, residents who did not know how to use the keycodes had to wait for a staff member to use the pin codes and accompany them to these areas.

The centre was clean and well maintained. However, the centre was found to be excessively warm. One resident was observed asking the staff for "air" and was standing at a window to access fresh air. Residents and staff spoken with confirmed that, at times, the premises was uncomfortably warm.

Residents were observed to eat in the dining rooms throughout the centre or have their meals in their bedroom, if they preferred. Place settings were laid out for residents prior to their meals, and residents appeared relaxed and comfortable in the dining spaces where they enjoyed conversation between fellow residents and staff during their meals. Menus were displayed on each table. Overall, residents

spoken with were very complimentary regarding the quality of the food provided. However two residents spoken with informed the inspector the "portions are small". The majority of residents wore clothing protectors to protect their clothing at meal times with one resident expressing " I feel like I have to wear the clothes protector- it's easier to say yes".

Residents had access to television, phones and newspapers. The social activities timetable which detailed the activities on offer each day was displayed throughout the centre. The activities available to residents included flower arranging, music, painting and exercises. On the day of inspection there was two dedicated activity staff members providing activities across four floors, therefore it was noted that only two units had access to organised activities at a time. Some residents were observed to spend significant periods of time in their chairs in the sitting room, with limited stimulation other than music or television playing in the background. During the afternoon, residents participated in a exercise programme which was facilitated by an external exercise group, with health care assistants in attendance to assist. However, the inspectors observed that residents were not actively encouraged by the staff to participate.

The inspectors spoke with many residents and a number of visitors throughout the day of inspection all of whom were complimentary about the staff, and had only positive feedback about their experiences of residing in the centre. Residents and family members spoken with expressed a good level of satisfaction with the care provided in Clondalkin Lodge Residential home. The residents reported that the staff "are fantastic" and "very kind" and they were "very happy" living in the centre.

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

## Capacity and capability

Overall, the findings of this inspection were that Clondalkin Lodge was a well-managed centre, where there was a focus on ongoing quality improvement to enhance the daily lives of residents. The inspectors found that residents were receiving good service from a responsive team of staff delivering safe and appropriate person-centred care and support to residents. However, the oversight and management of some areas of the service, including the submission of regulatory notifications, assessments and care planning, and managing behaviour that is challenging was not fully in line with the requirements of the regulations.

This was an unannounced inspection conducted to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspectors followed up on actions taken to address areas of non-compliance found on the previous inspection in June

2024, and also followed up on solicited and unsolicited information received by the office of the Chief Inspector since the last inspection.

The centre is owned and operated by Bartra Op Co (Clondalkin NH pres) Limited. There was a clear governance and management structure in place in the centre and the registered provider had ensured that the centre was adequately resourced to deliver care in accordance with the centre's statement of purpose. The person in charge was supported in their role by named members of the registered provider entity, as well as an assistant director of nursing and a number of clinical nurse managers. Other staff members included nurses, health care attendants, activity co-ordinators, housekeeping, laundry, catering, maintenance and administration staff.

The inspectors found that there was an appropriate skill mix and good supervision of staff in the centre. Staff were supported to attend essential training such as fire safety, manual handling and safeguarding vulnerable adults from abuse. Inspectors saw evidence on the day of inspection that further training was scheduled to take place in the coming weeks for staff outstanding training on fire safety.

Management oversight systems in place included meetings, committees, service reports and auditing. Key data was seen to be discussed during meetings attended by senior management in areas such as occupancy, staffing, clinical care, incidents, complaints, risk management, infection control and quality improvement. There was a comprehensive schedule of clinical audits in place to monitor the quality and safety of care provided to residents, and inspectors observed that improvements had been made to the auditing system in place following the findings of the last inspection. Records of audits showed that any areas identified as needing improvement had been addressed with plans for completion, or were already completed. Nonetheless, inspectors observed that not all care plans reflected the assessed needs of the resident. This was not identified by the completed care plan audits reviewed on the day of inspection.

A comprehensive annual review of the quality of the service in 2024 had been completed by the registered provider, in consultation with residents and their families. This review assessed the provider against the National Standards. It also identified areas for improvement and development to complete in 2025.

Inspectors reviewed a record of incidents that had occurred in the centre and identified that four incidents were potential safeguarding issues. These incidents had not been recognised as safeguarding issues and were therefore not notified to the Chief Inspector, in line with the requirements of Regulation 31, Notification of incidents.

## Regulation 15: Staffing

There were sufficient staff on duty to meet the needs of the residents and taking into account the size and layout of the designated centre. There was at least one registered nurse on duty at all times, on each floor of the centre.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to training. Staff had attended training to enable them to care for residents safely. There was good supervision of staff across all disciplines.

Judgment: Compliant

## Regulation 23: Governance and management

While there were oversight systems in place, the systems in place to ensure the care environment was safe, consistent, and effectively monitored was not always effective. This was evidenced by;

- There was poor oversight of the use of the ventilation systems in place throughout the centre to ensure they were kept at a comfortable temperature at all times. This was evidenced by no record of temperature checks being available on the day of inspection, and two residents and a number of staff reporting that the centre felt very warm at times.
- There was inadequate oversight of the process for displaying access codes required for exit doors from the units and passenger lifts, to ensure that the codes were displayed at all the necessary locations for residents who needed them.
- The oversight system for auditing care plans failed to identify some care plans did not reflect the assessed needs of the resident and contained conflicting information. This is further discussed under Regulation 5: Individual assessment and care plan.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The registered provider had failed to notify the Chief Inspector of Social Services of two safeguarding incidents that occurred in the centre.

Judgment: Not compliant

## Regulation 34: Complaints procedure

There was an appropriate complaints procedure in place. Inspectors viewed a sample of complaints saw that all complaints were responded to promptly and in line with their complaints policy.

Judgment: Compliant

## Quality and safety

Inspectors found that residents were receiving a good standard of care that supported and encouraged them to actively enjoy a good quality of life within Clondalkin Lodge Residential Home. Residents were found to be receiving care and support in line with their needs and preferences. However, gaps in regulatory compliance were identified by inspectors in relation to care planning and health care as discussed under Regulation 5 Assessment and Care Planning and Regulation 6 Health care. In addition inspectors found that restrictive practises were not always used in line with national policy and furthermore were not always recognised as a restrictive practise by staff.

A review of medicine management in the centre found that medications were managed in line with the centres' own policy and the requirements of the regulations. A review of prescription records outlined how medicines should be dispensed and were signed by the GP. Medicines controlled by the misuse of drugs legislation were stored securely and balances were checked by staff nurses twice daily. Inspectors reviewed the balances of a sample of controlled drugs which were seen to be correct.

Residents reported to feel safe and protected in the centre. The inspectors observed meaningful verbal and non-verbal interactions between staff and residents. Independent advocacy services were available to residents and the contact details for these were on display. There was evidence that residents were consulted with and participated in the organisation of the centre and this was confirmed by residents meeting minutes, satisfaction surveys, and from speaking with residents on the day. Following up on the last inspection in June '24 there were vast improvements observed in relation to residents access to activities.

The inspectors reviewed 11 care plans on the day of the inspection. While improvements had been made since the last inspection, such as regular auditing of care plans, this inspection found that some care plans contained conflicting information with the assessed needs of the residents and consequently could not be

relied on to clearly direct staff on the care they must provide to meet each resident's needs. This is discussed further under Regulation 5; Individual assessment and care plan.

There was evidence of good access to medical practitioners, through residents' own GP's and out-of-hours services when required. Systems were in place for residents to access the expertise of health and social care professionals through a system of referral, including speech and language therapists, dietitian services and tissue viability specialists. An in-house physiotherapy service provided group exercise and individual physiotherapy assessments. However, inspectors observed that not all residents received health care in line with their assessed needs, with particular regard to skin integrity.This is discussed further under Regulation 6: Health care.

While there was good systems in place around the use of restrictive practise in the centre, the inspectors found that restrictions on residents' access were not in line with the national restraint policy. This is further discussed under Regulation 7: Management of behaviours that challenge.

## Regulation 29: Medicines and pharmaceutical services

Medication management processes such as the ordering, prescribing, storing, disposal and administration of medicines were safe and evidence-based.The inspectors observed good practices in how the medicine was administered to the residents. Medicine was administered appropriately, as prescribed and dispensed.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

While, residents' needs were regularly assessed, residents' care documentation was not always updated to clearly direct staff regarding the care interventions they must complete to meet each resident's assessed needs and to ensure that pertinent information regarding each resident's care is effectively communicated to all staff. For example;

- Two residents care plans had conflicting information in their falls risk assessment and mobility care plans and had documented care that was not relevant to their needs.
- Another resident was assessed as low risk of absconsion using a validated tool for assessment, however the care plan identified the resident was high risk of absconsion and had documented restrictive measures in place which was not in line with the residents identified daily social care needs.

- One resident had conflicting information regarding the care they required as a result of the Covid outbreak with no evidence of a recent covid outbreak in the centre.

This is a repeat finding.

Judgment: Substantially compliant

## Regulation 6: Health care

Inspectors observed that not all residents received the appropriate medical and health care, having regard to their care plan prepared under Regulation 5. Inspectors noted that a number of pressure-relieving mattresses, for residents at risk of compromised skin integrity, were not set up accurately to correlate with the resident's weight. For example:

- One resident who weighed 90kgs had their mattress set at 200kgs
- One resident who weighed 74kgs had their mattress set at 90kgs
- One resident who weighed 80kgs had their mattress set at 100kgs.

Judgment: Substantially compliant

## Regulation 7: Managing behaviour that is challenging

Keycode locks on the doors and passenger lifts on each floor did not ensure that residents who may have difficulty understanding how to use the keycodes, could mobilise between the floors and access the outdoor space without having to seek staff assistance to use the keycodes. This was not in line with national policy.

Furthermore, a number of staff spoken with on the day of the inspection did not recognise these restrictions as a restrictive practise on the residents movements around the centre. Inspectors observed one resident who told them they enjoyed walking and who was seen to be able to mobilise independently being told by staff that they cannot exit out a door to another part of the centre.

Judgment: Substantially compliant

## Regulation 8: Protection

Systems were in place to ensure the management and protection of residents at risk of abuse. The safeguarding policy identified the processes in place to investigate

and respond to allegations or incidents of abuse. Staff have received updated training in safeguarding and were knowledgeable when asked about their role in safeguarding residents from abuse.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents had opportunities for recreation and activities. The provider consulted the residents through survey and regular residents meetings on the organisation of the service. Residents were facilitated to exercise their civil, political and religious rights.

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 23: Governance and management | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Substantially compliant |
| Regulation 7: Managing behaviour that is challenging | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Clondalkin Lodge Residential Home OSV-0008600

## Inspection ID: MON-0046527

## Date of inspection: 06/03/2025

**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 23: Governance and management | Substantially Compliant |

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

Clondalkin Lodge Residential Home has a well-defined management structure with clearly defined accountability and responsibility. The Person in Charge (PIC) works full-time in the centre and is supported by an Assistant Director of Nursing (ADON) and four clinical nurse managers, who are supernumerary. A regular auditing system is in place to ensure that the services provided are safe, appropriate, consistent, and effectively monitored. Following each audit, action plans are generated and signed off once completed. Audit findings are reviewed monthly by the Director of Nursing (DON) and ADON to identify trends, patterns, areas for improvement, and any gaps in care plans and healthcare records. Following the findings of this inspection the Person in Charge met with both the Assistant Director of Nursing and the Clinical Nurse Managers on the 14/03/25 who are responsible for conducting the audits to ensure that when carrying out the audits on care plans that they identify and ensure that care plans reflect the assessed needs of the resident and do not contain conflicting information.
Clondalkin Lodge has policies and procedures in place regarding Restrictive Practices and promotes a culture of a restraint-free environment, with excellent practices in place within the centre. It is the practice of the centre that, where a pin code is in place, the sample of the Month/year above the code is used to prompt residents regarding the code number. This code is changed on the first day of each month. Following feedback on the day of the inspection, a review was conducted on 7 March 2025 of all doors and lifts that had a PIN code. Of the 12 pin codes that are in place on all residents' doors and lifts, only two internal lifts and one internal door were missing this prompt. This was not intentional, and the code may have simply fallen off, as it is only stuck with tap. We have added a Pin code check to the night nurse checklist to ensure that all prompts are visible and present. Following a further review the keycodes were removed from the internal lifts to allow unrestricted movement between all floors within the home and have unrestrictive access to the internal gardens.

There is oversight in relation to the temperature in Clondalkin, the maintenance personnel conduct random checks of the temperature on each floor and record same.

They also ensure that the temperature stats are set at the right level. Staff are aware to ensure that windows are opened if they feel that the building is too warm or if requested to do so by the residents.

| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Clondalkin Lodge has policies and procedures in place regarding Restrictive Practices and promotes a culture of a restraint-free environment, with excellent practices in place within the centre. It is the practice of the centre that, where a pin code is in place, the sample of the Month/year above the code is used to prompt residents regarding the code number. This code is changed on the first day of each month. Following feedback on the day of the inspection, a review was conducted on 7 March 2025 of all doors and lifts that had a PIN code. Of the 12 pin codes that are in place on all residents' doors and lifts, only two internal lifts and one internal door were missing this prompt. This was not intentional, and the code may have simply fallen off, as it is only stuck with tap. Following this, we have added a Pin code check to the night nurse checklist to ensure that all prompts are visible and present.

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

Following the inspection the Person in Charge (PIC), Assistant Director of Nursing (ADON), Clinical Nurse Manager (CNM), and Staff Nurse (SN) reviewed all assessments and care plans to ensure they are consistent and clearly describe residents' care needs and preferences in a detailed, person-centred manner. On 18 and 20 March 2025, the PIC held a meeting with the SNs and emphasized the importance of developing and updating residents' care plans promptly, particularly following any changes to their condition and subsequent assessments. This ensures the care plans remain effective in guiding staff to deliver high-quality, person-centred care. The assigned CNMs of each floor are also to ensure this practice is followed and is consistent. A percentage of care plans are audited monthly as part of our clinical governance system. Any actions identified during these audits are addressed and signed off upon completion. In addition, the PIC conducts random audits of care plans whenever there is a change in a resident’s condition.

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

As discussed with the inspectors during the feedback on the day of inspection. A Standard Operating Procedure was being devised for Intentional Rounding, which staff nurses would conduct during their shifts. Included in this would be checks on the settings of pressure-relieving mattresses if in use by residents; the intentional rounding would commence on April 1, 2025. Additionally, we have included checks on the settings of the pressure-relieving mattresses in the weekly HCA checklist. This was all explained to the Staff nurses during their meeting on the 18th and 20th of March and to the HCAs on the 21st of March

| Regulation 7: Managing behaviour that is challenging | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

Clondalkin Lodge has policies and procedures in place regarding Restrictive Practices and promotes a culture of a restraint-free environment, with excellent practices in place within the centre. It is the practice of the centre that, where a pin code is in place, the sample of the Month/year above the code is used to prompt residents regarding the code number. This code is changed on the first day of each month. Following feedback on the day of the inspection, a review was conducted on 7 March 2025 of all doors and lifts that had a PIN code. Of the 12 pin codes that are in place on all residents' doors and lifts, only two internal lifts and one internal door were missing this prompt. This was not intentional, and the code may have simply fallen off, as it is only stuck with tap. Following this, we added a Pin code check to the night nurse checklist to ensure all prompts are visible and present.
After further review, the keycodes were removed from all the internal lifts to allow unrestricted movement between all floors within the home. This now also enables the residents to access our internal gardens safely and without the assistance of staff However, following a risk assessment, key codes were maintained at the exit to the units to ensure the residents' safety. This has been added to the Homes risk register and reviewed as required

## 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(c) | 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 | 01/04/2025 |
| Regulation 31(1) | Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence. | Not Compliant | Orange | 07/03/2025 |
| 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 | Substantially Compliant | Yellow | 01/04/2025 |

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| | accordance with paragraph (2). | | | |
| 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 | 01/04/2025 |
| Regulation 7(1) | The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. | Substantially Compliant | Yellow | 07/03/2025 |
| Regulation 7(2) | Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive. | Substantially Compliant | Yellow | 07/03/2025 |