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:	St. Camillus Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Shelbourne Road, Limerick
Type of inspection:	Unannounced
Date of inspection:	31 July 2025
Centre ID:	OSV-0008706
Fieldwork ID:	MON-0043995

About the designated centre

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

St. Camillus Community Nursing Unit is located on the grounds of St Camillus's Hospital Campus in Limerick city. The centre was registered with HIQA and opened in June of 2024 and the building provides a bespoke environment for care of the Older Person. The centre is Phase one of the capital build project to replace accommodation of the old residential Unit on campus. Phase 2 of the capital build project is scheduled to be completed in Quarter 1, 2026.

St Camillus's Community Nursing Unit is registered to accommodate 50 residents and caters for the needs of older persons who are of low, medium, high, or maximum dependency in relation to their activities of daily living. Each resident's needs are recognised as being unique to the individual, and a person-centred approach is taken to establish their needs and care pathways to assist them in maximising their activities of daily living.

The designated centre caters to both male and female residents over the age of 65. Occasionally residents under the age of 65 may be accepted depending on the individual requirements of the service user. Residents under the age of 18 cannot be accommodated in the centre.

The 50-bed unit is a two storey building consisting of two twenty five bedded units which are mainly single rooms with ensuite facilities. There are two twin-bedded rooms in each of the units. Each residents space is designed and created to provide a homely, safe, and person-centred environment. There are communal spaces within each of the units consisting of a dining area, sitting room, quiet room and treatment room. WiFi is available throughout the centre.

There are landscaped areas to the front of the building, an enclosed courtyard area in the centre of the building, an upper balcony outdoor area for the upper floor unit and a small enclosed garden with designated smoking area for residents use on the ground floor.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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 31 July 2025	09:10hrs to 17:45hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in St. Camillus Community Nursing Unit received individualised care and support from a team of staff who knew their needs and preferences. The service provided a supportive environment for residents with varying cognitive abilities, including those living with dementia. The service promoted residents' independence while ensuring they received appropriate social care. Residents reported feeling safe and expressed positive views about the staff and overall environment. However, a number of residents indicated dissatisfaction with certain aspects of their accommodation, particularly their bedrooms. Residents complaints included the inability to open their bedroom windows, the heat of their bedrooms, and ongoing building works outside. These issues were reported to have a negative impact on their quality of life and right to exercise choice.

The inspector arrived at the centre unannounced and conducted a walk-through of the premises. The inspector met with residents and staff and spoke in detail with nine residents about their experience of living in the centre. Staff were observed responding to residents' requests for assistance, and the delivery of care was noted to be calm, unhurried, and respectful. Following the walk-through, the inspector met with the person in charge for an introductory meeting.

There was a warm and welcoming atmosphere in the centre. Residents were observed spending time in their bedrooms during the morning, and staff were seen checking in on them. The inspector spoke with residents in their bedrooms, and overall, residents expressed satisfaction with the care they received and the attentive nature of staff. However, some residents raised concerns about their inability to open their bedroom windows. They reported that the temperature in the bedroom was excessively warm and uncomfortable, with some residents observed to be visibly perspiring. Residents described their room temperature as 'unbearable' and 'uncomfortable', and impacted on their ability to 'sleep well'. Residents stated that, although they had brought this issue to the attention of staff on multiple occasions, they had not received a satisfactory response. These concerns were also echoed in conversations with visitors to the centre.

The premises was generally laid out to meet the needs of the residents. The environment was spacious, bright and appropriately furnished to meet the needs of the residents. The inspector observed that there was a variety of communal areas and facilities available for residents to use throughout the centre. However, despite the availability of these spaces, two communal bathrooms, that were previously designated for residents, had been re-designated for staff use only.

The inspector observed fire safety concerns, including fire doors propped open with items of furniture and visibly gaps between some fire doors, which had the potential to impact on fire safety measures.

As the morning progressed, residents gradually made their way from the their bedrooms to the communal day room areas. Staff remained busy assisting residents throughout this time. However, the inspector observed that resident's privacy was not always fully respected during the delivery of personal care. In particular, privacy screens on bedroom doors were not consistently drawn, which compromised residents dignity during morning care provision.

Residents described some positive changes that had occurred in the centre in recent weeks. This included improvement in how information regarding their personal finances was shared and managed. Residents reported feeling respected and valued by being kept informed about how their personal finances were handled and how they could access them. Some residents also made use of lockable storage in their bedrooms to secure personal belongings. They expressed satisfaction that these storage options were safe and that they were supported in maintaining control over their own property.

The dining experience for residents was observed to be a social occasion. The inspector observed that staff provided sensitive and attentive support to residents during mealtimes. Staff created a calm and relaxed dining experience for residents and assistance was offered discreetly and respectfully, which allowed residents to maintain as much independence as possible. Residents appeared to enjoy their meals and engaged positively in the overall dining experience.

Residents were complimentary of the activities provided in the centre and the opportunities for social engagement. They spoke positively about the group activities, particularly games such as bingo, where prizes were offered, adding an element of fun and enjoyment. The centre had dedicated activity staff who facilitated both group and one-to-one sessions. Some residents required the assistance of staff to engage in activities, and staff were observed to provide that support in a kind and caring manner. These activities were scheduled in advance, and residents were kept informed about upcoming events. Residents were also encouraged to provide feedback on the activities they enjoyed and to suggest new activities they would like to try. Residents stated that this provided them with a sense of involvement and personal choice in their daily life.

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

Capacity and capability

This was an unannounced inspection carried out over one day by an inspector of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

The findings of this inspection were that the provider had taken action to establish effective governance and management systems to support residents' access to and control over their personal property and finances. However, this inspection found that the provider did not always ensure that appropriate systems of management were effectively implemented to monitor care, respond to risk, and to ensure timely action in response to known risks. Specifically, concerns were identified in relation to the premises and the impact of external building works on residents within the designated centre. A significant number of residents were unable to open their bedroom windows due to ongoing building works, which restricted ventilation and contributed to excessively warm temperatures in parts of the premises. There was no clear timeline for completion of the building works or resolution of this risk. As a consequence of these concerns, an urgent compliance plan was issued to the provider following this inspection.

The Health Service Executive is the registered provider of St. Camillus Community Nursing Unit. The organisational structure had changed since the last inspection in March 2025. In line with Condition 4 attached to the registration of the centre, the registered provider had nominated a person to participate in the management of the centre to ensure the person in charge was adequately supported and to ensure there was a clearly defined management structure in the designated centre. The organisational structure included a general manager of older person services, who was nominated to fulfil this role and provide operational oversight and support to the person in charge.

The person in charge of St. Camillus Community Nursing Unit remained responsible for the management of another designated centre for older persons, located on the campus grounds. The person in charge was supported in the administration of the service by an assistant director of nursing. The provider had strengthen the nurse management team through the appointment of a clinical nurse manager and there was ongoing recruitment of a second clinical nurse manager. However, the overall organisational structure remained inconsistent with the centre's statement of purpose, particularly in relation to the nurse management structure. This continued to impact on certain aspects of the quality of the service, including the supervision of staff, oversight of residents' assessments and care plans, the implementation of appropriate care pathways in response to resident's individual needs and risks, and the effectiveness of systems in place to monitor these areas.

Lines of accountability and responsibility for the oversight and management of resident's finances were clear. Responsibility for the day-to-day management of residents' monies remained with administrative staff based outside of the designated centre, and they continued to oversee tasks such as lodging funds to resident's accounts, preparing account statements, and ensuring residents had consistent access to their money, statements of accounts and transactions. The person in charge maintained overall oversight of this process and ensured that accurate financial records were kept in the designated centre, updated weekly and made available to the residents. This system was underpinned by policies and associated procedures. However, while systems were being established to provide residents

with access to their money outside of normal working hours, this system had not been effectively communicated to all staff responsible for its implementation.

The quality of the service was monitored through audits and the collection of key clinical performance indicators, which included data on residents' health care needs and associated risks, such as malnutrition and access to health care services. This information was compiled by staff in the centre and submitted weekly in a report for review by the senior nurse management team. However, the inspector found that some of the data escalated for review was inaccurate. For example, reports indicated that no residents were at risk of malnutrition or required further expert assessment. However, this information was not accurate and this impacted on the identification of residents at risk, and the timely referral of residents to appropriate care pathways for the assessment and management of the risk. Additionally, there was poor oversight of the systems of referral of residents for further expert assessment. Some residents had been referred for mobility and specialised seating assessment. However, there was no effective system in place to monitor this aspect of the service. Consequently, it was unclear if the appropriate assessments and interventions had been completed.

There were procedures in place to identify, assess, and record risks within the centres risk register, with corresponding control measures developed and implemented to manage the impact of identified risks on residents. Where risks fell outside the remit of the local management team to effectively manage, these were escalated to the provider for further review and action. However, the inspector found that escalated risks had not been adequately addressed by the provider. For example, building works occurring outside the designated centre were having a direct impact on residents. While this risk had been escalated to the provider in June 2025, there had been no action taken to effectively manage or mitigate the risk, and residents continued to be impacted.

A review of the records kept in the designated centre found that action had been taken by the provider, since the last inspection, to ensure that records relating to residents finances were maintained in line with the requirements of the regulations. However, the inspector found that some records were not maintained in line with the requirements of Schedule 2, 3 and 4 of the regulations, as they were incomplete. This included records pertaining to incidents involving residents, and records of nursing care provided to residents.

The management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner. The inspector received information from residents consistent with complaints regarding the quality of the service. While these issues had previously been brought to the attention of the management, the complaints were not appropriately documented or managed within the complaints register, or in line with the centre's own complaints management policy.

All staff were facilitated to attend training appropriate to their role, such as fire safety, safeguarding of vulnerable people, and supporting residents living with dementia. Additional training had also been provided in relation to managing

residents at risk of malnutrition and supporting residents to manage their responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). However, staff did not always demonstrated an appropriate awareness of this training.

The supervision of staff was not always effective as the inspector observed poor practice whereby fire doors were held open with pieces of furniture, effectively compromising their function to contain the spread of smoke and fire, despite staff having received training in fire safety management.

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of residents, in line with the statement of purpose. There was sufficient nursing staff on duty at all times, and they were supported by a team of health care staff. The staffing compliment also included catering, housekeeping, administrative and management staff.

Judgment: Compliant

Regulation 16: Training and staff development

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

- lack of oversight of the residents' clinical documentation to ensure the assessment and care planning were accurate and up-to-date.
- poor supervision of staff to identify and respond to residents nutritional needs and risks to ensure the appropriate pathway of care was implemented in response to a resident's risk of malnutrition.
- poor fire safety awareness as evidenced by fire doors wedged open.

Judgment: Substantially compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not always in line with the regulatory requirements.

A full and complete record of any incident in which a residents suffered abuse or harm was not provided for review. The records of adverse incidents involving residents provided for review did not contain the details required by Schedule 3(4)(j) of the regulations. This included information pertaining to the names of the person(s) in charge of the centre, supervising the residents, and names and contact details of any witnesses, and results of investigations and action taken.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place to monitor the quality of the service were not fully effective to ensure the service provided to residents to residents was safe and effectively monitored. For example;

- There were ineffective systems of oversight in place to ensure accurate and consistent recording of resident's weights to identify unintentional weight loss, and subsequent risk of malnutrition. This was compounded by ineffective systems of audit. For example, information regarding the assessment of resident weights was escalated to the senior nurse managers on a weekly basis. However, it had not been identified that this information was not accurate. Consequently, quality improvement actions could not be developed.
- Risk management systems were not effectively implemented. Risks relating to the premises that had been escalated to the provider had not been reviewed or acted upon in a timely manner. This adversely affected the quality of life experienced by some residents as detailed under Regulation 17, Premises.
- There was poor oversight of the centre's complaints management system to ensure complaints were managed in line with the requirements of the regulations, and of the system of referral to ensure residents had timely access to health care professionals.
- The communication systems in place to ensure that all staff were aware of changes to policies were not fully effective. For example, some staff responsible for implementing the system were not fully informed of the current procedure and continued to reference the outdated, more restricted process for residents' to access their finances. This meant that the system in place did not fully ensure residents' could access their finances, in line with the current procedures.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were not always recorded and managed in line with the centres own policy and the requirements of the regulation. For example, not all complaints or expressions of dissatisfaction with the service had been documented and investigated and therefore there was no plan in place to address the issues of concern. The inspector was informed by residents and their families that they had communicated complaints regarding the premises to the staff in the centre, however, there was no record of these complaints documented.

Judgment: Substantially compliant

Quality and safety

Overall, resident's health and social care needs were maintained by a satisfactory standard of evidenced-based care, and residents were observed to be safe and content within the centre. While the provider had taken some action to improve the quality of resident's' care plans, these plans did not always reflect individual needs and were not consistently updated following a change in those needs. This inspection also found that the aspects of the physical environment had a significant impact on residents, particularly in relation to ventilation and temperature control. In addition, fire safety and health care were found not be be in full compliance with the regulations.

The premises was generally designed and laid out to meet the individual and collective needs of the residents. There was a variety of indoor communal and private space available to residents. The centre was bright and spacious. Residents had access to secure and pleasant garden space that was appropriately furnished. However, the inspector found that residents experienced uncomfortable temperatures in several bedrooms due to restricted ventilation, caused by external building works that prevented windows from being opened. The fans provided were ineffective in alleviating the heat.

A review of fire precautions in the centre found that records with regard to the maintenance and testing of the fire alarm system, emergency lighting and fire-fighting equipment were maintained and available for review. A summary of residents Personal Emergency Evacuation Plans (PEEP) were in place for staff to access in a timely manner in the event of a fire emergency. Staff demonstrated an appropriate awareness of the evacuation procedure and an awareness of the actions in place to mitigate the risk fire to residents. However, a number of fire doors located throughout the centre were not functioning appropriately. There were significant gaps between corridor fire doors which had the potential to impact on the containment of smoke and fire.

A sample of residents individual assessment's and care plans were reviewed. All residents had a care plan in place and there was evidence that some care plans had

been developed using validated assessment tools. However, a review of some residents records found that residents' actual care needs were not always appropriately assessed and incorporated into their care plan. For example, residents who had experienced weight loss did not have an appropriate assessment of their weight completed. Consequently, the care plans for a number of residents did not identify their risk of malnutrition or provide person-centred guidance to staff on the management of the risk.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs, and residents had access to their GP, as requested or required. Arrangements were in place to refer residents to health and social care professionals for further expert assessment. However, a number of residents referred to physiotherapy and occupational did not have timely access to the required assessments and interventions.

Residents were supported to retain control over their clothing, personal possessions and finances. Suitable storage facilities were provided, laundry services ensured clothing was returned to the correct owner promptly, and financial records were accessible to residents at all times.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff spoken with demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse. Procedures were in place for the management of residents' monies and locked storage was provided for residents' valuables. The provider supported nine residents to manage their pension and welfare payments.

There were opportunities for residents to consult with management and staff on how the centre was run. Minutes of residents meetings were reviewed and evidenced that feedback provided by residents at the meetings was acted upon to improve the service for residents. There was an activity schedule in place and residents were observed to be facilitated with social engagement and appropriate activity throughout the day.

Residents were encouraged and supported by staff to maintain their personal relationships with family and friends. Visitors were welcomed in the centre. Visitors were complimentary of the care provided to their relatives.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 12: Personal possessions

Residents retained control over their clothing, which was laundered regularly and returned to them. Bedrooms were equipped with sufficient storage to allow residents to maintain their cloths are other personal possessions.

Records of residents finances were securely maintained within the designated centre and were available to residents at any time. Residents were informed about how to access this information at their request. There were sufficient supports in place to ensure residents retained control over their finances.

Some residents chose to manage their privacy property within their own bedroom and were provided with locked storage units to ensure privacy and security.

Judgment: Compliant

Regulation 17: Premises

Following this inspection, the provider was required to submit an urgent compliance plan to address significant environmental concerns impacting residents' comfort and well-being. A substantial number of residents were affected by restricted ventilation caused by external building works, which prevented windows from being opened. Residents and visitors reported uncomfortable temperatures in several bedrooms, and the fans provided were considered ineffective in alleviating the heat. Concerns were also raised about unsuitable temperatures in other areas of the centre, including the dining rooms. The providers response provided assurance that the risk was adequately addressed and managed to reduce the impact on residents.

In addition, the provider did not ensure that the premises were in accordance with the Statement of Purpose. On each floor, a communal bathroom had been re-designated for staff use only, with signage erected to indicate this change. This was contrary to the layout of the designated centre as outlined in the Statement of Purpose and reflected on the approved floorplan, and it resulted in a reduction of communal bathroom facilities available to residents.

Judgment: Not compliant

Regulation 28: Fire precautions

The following aspects of fire safety were not in compliance as a result of inadequate arrangements for the containment of fire.

- Several fire doors had significant gaps, which had the potential to compromise their effectiveness in the containment of smoke and fire.
- Poor practice was observed where fire doors were held open using furniture and items such as bins in high-risk areas.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

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

- Residents did not always have a comprehensive assessment of their needs completed on admission to the centre. One residents pre-admission and admission documentation on file related to a different designated centre. As a result, the residents needs were not fully or comprehensively assessed or updated on admission to the centre, and there was uncertainty regarding an important aspect of the residents health status, which staff were unaware of as a result of incomplete admission assessments.
- Some residents who had experienced significant weight loss did not have an accurate assessment of their nutritional risk completed. Consequently, the care plan did not detail the interventions necessary to support residents with their nutritional care needs. As a result, staff did not have the required information to support the resident's assessed needs
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan for a resident with complex medical care needs did not reflect the specific nursing interventions required to specifically manage those needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents did not have timely access to health care professionals for further expert assessment when clinically indicated. For example, two residents referred to physiotherapy services in January 2025 for further assessment had not been reviewed by a physiotherapist at the time of this inspection.

In addition, some residents experienced significant wait times to access the services of some health care professionals. For example, one resident waited five months to access occupational therapy services.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect residents from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

The provider had a plan in place to ensure residents pensions and social welfare payments were managed in line with best practice guidance.

Judgment: Compliant

Regulation 9: Residents' rights

All residents who spoke with the inspector reported that they felt safe in the centre and that their rights, privacy and expressed wishes were respected.

Residents rights and choice were respected in the centre and they had consistent access to a variety of activities, seven days a week. Residents who did not participate in group activities were provided with one-to-one time. Residents expressed high levels of satisfaction with the activities in the centre.

Residents attended regular meetings and contributed to the organisation of the service. Residents confirmed that their feedback was used to improve the quality of the service they received.

Residents' civil rights were supported and promoted. Residents could access and manage their personal finances in a timely manner. Information in relation to their financial accounts was maintained and accessible to residents, enabling them to monitor their own accounts and financial transactions.

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	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Substantially compliant
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 St. Camillus Community Nursing Unit OSV-0008706

Inspection ID: MON-0043995

Date of inspection: 31/07/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Residents' clinical documentation, including assessment and care planning, has been reviewed by nursing management to ensure they are all accurate and up-to-date. Staff Nurses have been memtored in respect of maintaining up to date documentation and there is a system in place to monitor compliance with updating care plans effectively. The assessment scores of MUST have been reviewed in each unit to ensure that they are calculated correctly and there is now a link nurse in each unit who has been given individual training in completing MUST to ensure every nurse is supported in using this risk assessment effectively, to optimize timely intervention where potential risk is established. All staff have been reminded that fire doors cannot be propped open at any time. This is checked during each shift and communicated in each handover and safety pause.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A copy of all NIMS reports are now kept within the designated centre. This ensures that all information required in the regulation, in respect of incidents, is retained on site for ease of review.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The management systems to monitor the quality of the service have been reviewed and improved to ensure safe services and efffective monitoring of care and documentation practises.
• MUST has been reviewed, increased training has been given and there is a system in place to monitor compliance. The nursing office has linked with each unit and there is a system in place for ad hoc review of assessments and the use of assessment tools. The night sister is also checking to ensure if risk assessment tools are being effectively utilised especially where there has been any change in a residents overall condition. The dietician for the centre has completed nutritional assesments on residents who were found to be a MUST of 2 (there were 3 in total when assessments were reevaluated).
• Risks escalated to the Provider in respect of the premises have had effective corrective actions implemented to ensure the wellbeing of the residents.
• All staff have been reminded of the importance of recording every complaint to ensure it is accurately documented, actioned and reviewed in line with the complaints policy.
• Daily checks have been commenced to ensure that all staff have awareness of the centre's policies and that they are kept up to date on changes in policy within the centre. These daily rounds are being documentated and any gaps in knolwedge of local policies and procedures is being addressed immediately.
• On site face to face training has been completed with the CNM2's in incident and risk management.
• Accuracy of reports and information submitted to the nursing office is being checked for accuracy within the units by the nursing office.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All staff have been reminded to record every complaint, the actions taken and review satisfaction in the corrective actions in line with the centre's complaints policy.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Corrective action was undertaken on the air exchange unit and the programming has been adjusted to ensure the internal environment of the centre is comfortable for our residents. There is ongoing temperature monitoring in rooms and communal areas to ensure that temperatures are kept within required ranges. Temperatures are ranging from 19 to 22 predominantly over the 24 hr period. This monitoring is being done by both the staff within the unit and the maintenance team daily. Any changes to the range of temperatures is reported to the nursing office and the nursing office team do ad hoc checks on communal and rooms temperatures daily. There are fans available for resident use as required. Residents are reporting a comfortable environment and are being communicated with on an ongoing basis. Environment comfort is also discussed in the residents meetings.

Bathrooms that had been marked as being for staff have been re-designated as communal use bathrooms for residents in the unit as per the statement of purpose floor plans. All staff have been reminded that no changes can occur for designated use of any area in the centre without the appropriate procedure being followed including application to HIQA to vary the floor plan.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All staff have been reminded that fire doors are not to be propped open at any time. Further information sessions have been facilitated through Safety Pause in respect of the fire system in the centre. Management are undertaking ad hoc checks with staff daily to ensure there is awareness in all team members of all fire precautions in the centre. There is a schedule of training in place to ensure that staff are up to date in their fire training.

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:
Care plans have been reviewed and amended where required to reflect the individualised needs of the residents. Ongoing audit through peer to peer auditing and ad hoc care plan checks by management are being undertaken to monitor compliance with care plans reviews and ensure they contain the correct information on the residents status and individual needs.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: Timely access to health care professionals for expert assessment where clinically indicated has been put in place. Provision of regular physiotherapy and occupational therapy hours has now been assigned to the designated centre. This has addressed the delays that had been experienced by some residents at the time of inspection.	

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	15/08/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Red	08/08/2025
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.	Substantially Compliant	Yellow	01/08/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	15/08/2025

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/08/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	01/08/2025
Regulation 5(2)	The person in charge shall 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	Substantially Compliant	Yellow	15/08/2025

	resident immediately before or on the person's admission to a designated centre.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	15/08/2025
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.	Substantially Compliant	Yellow	15/08/2025