



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	West Clare Nursing Home St Theresa's Kilrush
Name of provider:	Sundyp Limited
Address of centre:	Leadmore East, Kilkee Road, Kilrush, Clare
Type of inspection:	Unannounced
Date of inspection:	19 February 2025
Centre ID:	OSV-0000451
Fieldwork ID:	MON-0040598

About the designated centre

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

St. Theresa's Nursing Home is a purpose built single-storey facility which can accommodate up to 39 residents. It is located close to the town of Kilrush. It accommodates both male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older persons who require general nursing care, respite, convalescence, palliative and dementia care. Bedroom accommodation is provided in 24 single bedrooms, six twin bedrooms and a three bedded room. All of the bedrooms have en suite toilet and shower facilities, except one which has direct access to its own dedicated shower/toilet room. There is a variety of communal day spaces including day room, dining room, sun rooms, smoking room, oratory and front reception area. Residents also have access to secure enclosed garden area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	35
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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
Wednesday 19 February 2025	09:00hrs to 17:45hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in West Clare Nursing Home St. Theresa's Kilrush were complimentary of the staff who provided them with care and support in a caring and respectful manner. Residents spoke positively about staff as individuals who made them feel safe, and described how staff encouraged them to be independent and to engage socially with other residents. The only source of dissatisfaction expressed by residents was with the provision of meaningful activities.

The inspector arrived at the centre unannounced and was met by a clinical nurse manager who was deputising for the person in charge in their absence. Following an introductory meeting, the inspector walked through the centre and met with residents, staff and visitors.

On a walk around the centre, staff were observed busily attending to the morning care needs of residents. There was a relaxed and calm atmosphere, and polite conversation was overheard between residents and staff. The inspector spoke with a number of residents in the communal day room and in their bedrooms. Residents reported that staff were kind, caring, and attentive to their needs. They described how staff respected their privacy and their right to choose in many aspects of their daily life. For example, some residents preferred to remain in bed until late in the morning, and staff respected their choice.

The inspector spent time during the morning in the dayroom, located adjacent to the reception area. Some residents were observed watching mass on television while others were asleep in their chairs. There was no social activities taking place in the morning. While staff were observed checking on residents in between their morning duties, those interactions were time-limited and residents were observed to spend long periods of time with no social engagement or activity until the television was switched on mid-morning.

The lunch-time experience was observed to be a pleasant occasion for residents. Staff were observed providing discreet assistance and support to residents in the dining room, day room, and to those residents who remained in their bedroom.

Resident bedrooms were found to be clean and organised and many were decorated in a manner that reflected the residents' preference including photographs, soft furnishings and ornaments. Residents described that they were happy with their bedrooms. There was access to television and call bells in all bedrooms.

The design and layout of the premises was generally suitable for its stated purpose and met the residents' individual and collective needs. The centre was seen to be bright and tastefully decorated throughout. Communal areas were seen to be well-used by residents throughout the day. The centre was found to be well-lit and warm and residents described the centre as homely and comfortable. Resident complimented the colourful décor of the centre and the addition of decorations to

celebrate Valentines Day. A programme of refurbishment work was underway at the time of this inspection. The provider was increasing the door widths of a number of bedrooms and installing new fire resistant doors. Residents told the inspector that this had minimal impact on their day-to-day life in the centre and that noise and disruption was appropriately managed.

There were some activities provided to residents in the afternoon in the form of a lively game of bingo. Residents appeared to enjoy this activity and the social engagement with staff. Other residents were observed sitting outside for brief periods throughout the day. Residents told the inspector that while staff endeavoured to engage with them throughout the day, staff were busy assisting other residents which meant meaningful social engagement and activities were restricted to the afternoon.

Residents said that they felt listened to and had the opportunities to make choices in their daily lives. There were resident meetings to discuss any issues they may have and to suggest ideas on how to improve the centre. Advocacy services were available to all residents. Details of independent advocacy groups were on display in the centre.

Visitors were seen coming and going throughout the day. Visitors expressed their satisfaction with the quality of the service provided to their relatives, and confirmed that there were no visiting restrictions in place. They complimented the staff and management, who they described as 'so kind and caring', and praised the efforts of staff to encourage residents to feel at home in the centre.

The following sections of this report detail the findings in relation to the capacity and capability of the provider, and describes how these arrangements support the quality and safety of the service provided to the residents.

Capacity and capability

This 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). Notifications submitted by the provider in relation to adverse incidents involving residents, and unsolicited information received by the Chief Inspector were also reviewed on this inspection.

The findings of this inspection were that the centre had an established management structure that was responsible and accountable for the provision of safe and quality care to the residents. Following the previous inspections of the centre, the provider had taken action to ensure that most records were maintained in line with the requirements of the regulations. However, the inspector found that accountability and responsibility for the oversight of some aspects of the service was not fully effective. This included the oversight of risk, complaints, residents care records,

health care, and residents' rights, which were not in full compliance with the regulations.

The inspector reviewed unsolicited information received by the Chief Inspector. The information pertained to concerns regarding the quality of care delivered, including health care and the management of complaints. Some of this information was found to be substantiated on this inspection.

The registered provider of West Clare Nursing Home St. Theresa's Kilrush is Sundyp Limited. A director of the company represented the provider in engagement with the Chief Inspection, and was also the person in charge. The person in charge was supported by an assistant director of nursing, a clinical nurse manager, and a team of nursing, care, and support staff.

While there was a stable management structure within the centre, lines of authority and accountability were not always clearly identified. The roles and responsibilities of the assistant director of nursing and clinical nurse management were unclear as their role included both the provision of direct nursing care to the residents and supervision of the service. However, a review of the management systems within the centre found that the management and supervisory component of their role was not consistently carried out. This was found to have an impact on the supervision and monitoring of some aspects of the service such as the oversight of residents' clinical care records, referral and access to health care, and the systems in place to evaluate and improve the quality and safety of the service.

The centre had management systems in place to monitor the quality and safety of the service provided to residents. Key aspects of the quality of resident care were collected and reviewed monthly and included information in relation to falls, weight loss, nutrition, complaints, medication, and other significant events. However, it was not always evident that this information was analysed to identify areas for quality improvement and intervention. For example, where residents weight-loss was reported, the information was not examined to ensure appropriate nutritional monitoring was in place, an appropriate care plan was developed, and referrals for further expert assessment were made, in line with the centre's nutritional management procedures. Consequently, this impacted on the quality of care provided to some residents.

There were communication systems in place and regular meetings took place with each department. Agenda items included resident care needs, care planning, infection control and staff training. Records demonstrated that governance meetings took place monthly and this forum was used to discuss items such as clinical care, key performance indicators, audits and complaints.

A review of the risk register evidenced that some clinical and environmental risks were assessed and had been categorised according to their level of risk to residents. There was evidence that the provider was proactive in identifying risks that may impact on the safety and welfare of residents in the centre, and had put measures in place to manage the risk. This was evident through the provider's management of fire safety works in the centre where action had been taken to reduce the risk of fire

and the impact of noise and dust that may be caused during fire safety works. However, a review of the risk register found that the provider did not manage all known risks in line with the centre's own risk management policy. For example, consistent access to medical professionals was an issue impacting the care of some residents in the centre. The provider had not assessed the potential risks to residents. Consequently, there was no plan in place to appropriately manage the risk and some residents continued to be impacted.

The provider had taken action to improve the oversight of record management systems in the centre. Records pertaining to staff personnel files, adverse incidents, and the directory of residents were maintained in line with the requirements of the regulations. As part of a quality improvement plan, the provider was in the process of transferring all clinical care records to an electronic record systems to support the oversight of this area of the service.

Comprehensive documentation of accidents and incidents were recorded. A review of the records of adverse incidents involving residents showed that incidents were appropriately documented, investigated, and learning was identified to improve the quality and safety of the service provided to residents.

Notifiable incidents, as detailed under Schedule 4 of the regulations, were submitted to the Chief Inspector of Social Services within the required time-frame.

There was a complaints policy and procedure in place which met the requirements of Regulation 34, Complaints procedure. The policy detailed the personnel responsible for the management of complaints and specified the time-lines for which a complaint must be recorded, acknowledged, investigated, and a response issued to the complainant. The inspector was informed that two complaints had been received by the centre. However, a review of the complaints register found that the complaints had not been documented in the complaints register, in line with the centres own policy. In addition, there was no record of one of the complaints being investigated or resolved to the satisfaction of the complainant.

The centre had a stable team of staff that ensured that residents benefited from continuity of care from staff who knew their individual needs. The team providing direct care to residents consisted of registered nurses, and a team of health care assistants. While the provider prioritised the direct care of residents and ensured staffing levels were maintained to support residents with their physical care needs, staffing resources were not made available to support the social care and well being of residents.

Staff had access to education and training appropriate to their role and a training schedule was in place. Staff had completed training such as fire safety, safeguarding of vulnerable people and manual handling techniques.

The arrangements in place to supervise and support staff in some aspects of the service was not fully effective. For example, staff were not appropriately supervised to ensure residents' care records were appropriately maintained.

Regulation 16: Training and staff development

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

- a lack of oversight of the residents clinical documentation to ensure that residents assessments and care plan were accurate and up-to-date to reflect the current care needs of the residents.
- poor allocation and supervision of staff resources meant that residents were not supported to enjoy meaningful social engagement and activity.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that staffing resources were organised and managed to ensure person-centred, effective and safe services were provided to residents, in line with the centre's statement of purpose. Staffing rosters evidenced that staffing resources were not made available to cover unplanned leave in the activities staff roster for a period of over two months. This impacted on the provision of meaningful social engagement and activities for residents.

The roles and responsibilities of the nurse management team were not clearly defined. While there was a nurse manager on duty daily, their role involved supporting the direct provision of nursing care to residents and providing nursing oversight and governance. However, this inspection found that the oversight of key aspects of the service such as the management of risk, clinical care records, supervision of staff, and the systems of management were not effectively implemented.

The management systems in place to monitor the quality of the service were not fully effective to ensure the service provided 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, a nutritional audit completed in December 2024 assessed the quality of care provided to residents at high risk of malnutrition. The audit reflected full compliance, with no quality improvement required, despite the appropriate care pathway not being implemented for a number of residents with significant weight-loss accommodated in the centre at that time.

- Risk management systems were not effectively monitored or implemented. The centre's risk register did not contain known risks in the centre such as the risk associated with construction works, inadequate access to some health care services, and changes to the organisation of staffing resources. This meant that actions to mitigate and manage risks to residents had not been identified or subject to review.
- There was poor oversight of the centre's complaints management system to ensure complaints were managed in line with the requirements of the regulations.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifiable events as set out in Schedule 4 of the regulations were submitted to the Chief Inspector of Social Services within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaints register found that complaints were not always managed in line with the requirements of the regulations.

- A record of a complaint did not evidence that an investigation had been carried out into concerns raised regarding the quality of care. For example, the complaint record did not contain an investigation of all aspects of a complainant's concerns regarding the quality of care provided to a resident including hydration and skin care.
- The response issued to a complainant in response to their complaint did not include information on whether or not their complaint was upheld, the reason for the decision, improvements recommended and details of the review process, in line with the requirements of the regulations.
- Complaints were not fully and properly recorded in the centre's complaint register, in line with the centre's complaints procedure or the requirements of this regulation.

Judgment: Not compliant

Quality and safety

Residents living in the centre received care and support which ensured that they were safe, and that they could enjoy a good quality of life. Residents reported feeling safe and content living in the centre. There was a person-centred approach to care, and residents' well-being and independence were promoted. However, some aspects of the care delivered did not ensure that a high quality service was consistently provided, particularly in relation to social care and health care. In addition, residents' individual assessments and care plans were not always maintained in line with the requirements of the regulations.

A sample of assessments and care plans were reviewed and found that while each resident had a care plan in place, care plans were not always informed by an accurate and up-to-date assessment of the residents needs. For example, assessments to identify residents who may be at risk of malnutrition were not complete. Therefore, some care plans were not developed in line with the clinical risk to the residents. Furthermore, some care plans were not reviewed following a change a' residents condition.

A review of residents' records found that there was regular communication with residents general practitioners (GP) regarding their health care needs and arrangements were in place to ensure that the general practitioners were informed of residents who showed signs and symptoms of physical deterioration.

Residents could access the expertise of allied health care professionals such as dietetic services, and speech and language therapists for further expert assessment through a system of referral. However, residents were not always appropriately referred for further expert assessment when clinically indicated.

Arrangements were in place to ensure that the transfer of residents from the designated centre to hospital, or other health care services, occurred in line with the requirements of the regulations. This included arrangements to ensure information pertinent to the care of residents were communicated to the receiving health care facility.

The provider had ensured that there were adequate arrangements in place for the oversight and review of restrictive practices. A restrictive practice register was maintained which recorded and monitored the use of each restraint. The identified restrictions assessed all risks associated with the use of each restriction and detailed the alternative options considered. Residents were involved in decision-making regarding the use of restrictive practices.

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.

Visitors were observed coming to the centre on the day of inspection. Inspectors spoke with a small number of visitors who said they were happy with the care their relative received, and that they were free visit when they wished.

While there was an activity schedule in place, residents were not always provided with activities in accordance with their interests and capacities. A review of activity records showed that there was an over-reliance on activities that did not promote social engagement. This included activities such as television viewing.

Residents stated that they felt at home in the centre and that their privacy and dignity was protected. They told the inspector that they were free to exercise choice about how to spend their day.

Resident meetings took place frequently and records indicated a high level of attendance by residents. These meetings provided residents' with opportunities to be consulted about and participate in the organisation of the centre. Residents had access to independent advocacy services.

Regulation 11: Visits

The registered provider had arrangements in place to facilitate visiting in the centre. Residents could meet their relatives and friends in the privacy of their bedrooms or in designated visiting areas in the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were provided with appropriate facilities within their bedroom accommodation for the safe storage of their personal possessions and clothing. Each residents was provided with lockable storage.

Residents clothing was laundered on-site and systems were in place to ensure residents clothing was identifiable to minimise the risk of items of clothing become lost or misplaced.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Arrangements were in place to support the transition of residents from the designated centre to hospital or home in consultation with each resident, including the resident's general practitioner (GP).

Information regarding the residents health and social care needs were provided to the resident concerned, hospital, general practitioner, family or carer.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

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

- Care plans were not always informed by assessment of the residents care needs. For example, two residents who had experienced significant weight loss did not have an assessment of their weight and risk of malnutrition completed. Consequently, care plans did not contain accurate information to guide the care to be provided to the residents.
- Care plans were not always updated when a residents condition changed. For example, a care plan had not been updated to reflect changes in a resident's modified consistency diet that was prescribed in November 2024.

Judgment: Substantially compliant

Regulation 6: Health care

The arrangements in place to ensure residents were provided with consistent access to medical and health care including did not fully meet the requirements of the regulations. For example;

- Residents who had experienced significant weight- loss had not been appropriately referred for further expert assessment, in line with the centres nutritional management policy and procedure.
- The recommendations of a speech and language professional had not been fully implemented. A resident was not provided with a therapeutic consistency diet, in line with their assessed needs.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

A restraint free environment was supported in the centre. Each residents had a full risk assessment completed prior to any use of restrictive practices. Assessments were completed in consultation with the residents and multidisciplinary team.

Arrangements were in place to support residents who experienced 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). Staff had up-to-date knowledge to support residents to manage their responsive behaviours and detailed how a person-centred, respectful and non-restrictive approach to care was implemented.

Judgment: Compliant

Regulation 8: Protection

A policy and procedures for safeguarding vulnerable adults at risk of abuse was in place to provide support and guidance to staff in recognising and responding to allegations of abuse.

All staff had appropriate vetting completed by An Garda Síochána prior to commencing employment in the centre. Staff spoken with displayed appropriate knowledge of the different kinds of abuse and the action they would take if they witnessed any form of abuse. The training records showed that staff had participated in training in relation to the safeguarding and protection of vulnerable persons.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were not provided with adequate opportunities to participate in activities in accordance with their interests and abilities.

Residents spoken with reported that the quality of meaningful activities and social engagement did not meet their individual needs and preferences. Residents stated that while health care staff were allocated to provide activities in the afternoon, there was limited social engagement with staff until that time.

The inspector observed residents spending long periods of time without social interaction. The inspector observed that one activity occurred on the day of inspection. Residents told the inspector that scheduled activities such as walks, chair exercises, and one-to-one chats were not regularly occurring.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for West Clare Nursing Home St Theresa's Kilrush OSV-0000451

Inspection ID: MON-0040598

Date of inspection: 19/02/2025

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: A comprehensive review of staff allocation and the supervision of clinical documentation has been conducted to ensure that residents' assessments and care plans are accurate, up-to-date, and reflective of their current care needs. Care plans have been distributed among the nursing staff, with the ADON and CNM assigned specific care plans for monthly auditing and review. Compliance will be monitored through discussion at the monthly governance meetings. Additionally, a full review of staff allocation and supervision has been undertaken to enhance the provision of meaningful social engagement and activities that residents find enjoyable.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Response to HIQA Compliance Plan – Regulation 23 Governance and Management 23(a) – Staffing Resources The provider acknowledges the gap in staffing resources and its impact on the provision of meaningful social engagement and activities. The following corrective actions have been implemented to address this issue and ensure ongoing compliance:	

- A full review of staffing rosters has been completed to ensure appropriate staffing levels are maintained, including cover for unplanned leave in the activities staff roster.
- A relief panel has been established to provide immediate cover for unplanned staff absences, ensuring consistent delivery of scheduled activities and social engagement.
- The activities schedule has been revised and expanded to ensure residents' social and recreational needs are met consistently.
- A monitoring system has been introduced to track staff availability and identify gaps proactively, allowing for timely resource allocation.
- The centre's statement of purpose has been updated to reflect the provider's commitment to ensuring adequate staffing levels to support

23(b) – Nurse Management Roles and Responsibilities

To address the issues related to the oversight and management of key aspects of the service, the following actions have been implemented:

- The roles and responsibilities of the nurse management team have been clearly defined and communicated. A new organisational chart has been introduced to provide clarity on lines of accountability.
- A designated Clinical Nurse Manager (CNM) is now responsible for oversight of risk management, clinical care records, and staff supervision.
- Monthly governance meetings have been established to review clinical performance, staffing issues, and service quality.
- A supervision and appraisal system has been implemented to ensure consistent monitoring of staff performance and adherence to clinical standards.
- A governance framework, including key performance indicators (KPIs), has been introduced to measure the effectiveness of nurse management oversight and drive continuous improvement.

23(c) – Risk Register

The risk register has been thoroughly reviewed and updated to reflect all current risks affecting the centre, residents, and staff. The following measures have been introduced to ensure ongoing oversight:

- A monthly review of the risk register is now embedded into the governance structure.
- All identified risks are tracked, with mitigation measures implemented and monitored for effectiveness.
- A risk escalation process has been introduced to ensure timely intervention where emerging risks are identified.
- All nurses and senior management have received re-training on conducting nutritional assessments and auditing care plans. Nutrition training online has been completed and awaiting in house support training in line with the online training Scheduled before 30.04.2025.
- Nutritional risk assessments and care plans will be audited monthly by the senior management team, with findings reviewed at the monthly governance meetings to ensure accuracy and implement robust corrective actions where necessary.

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Complaints Process Response to HIQA Compliance Plan – Regulation 34 Complaints Procedure The provider acknowledges the need to strengthen the complaints management process to ensure full compliance with regulatory requirements. The following corrective actions have been implemented to provide assurance that all complaints will be identified, documented, and investigated in line with the regulations: Review and Documentation • A full review of the complaint's procedure has been completed to ensure it reflects the requirements of Regulation 34. • The complaints register has been reorganised and updated to ensure all complaints are recorded systematically, including the nature of the complaint, actions taken, and the outcome. • A tracking and monitoring system has been introduced to ensure real-time oversight of all complaints and their resolution status. Investigation and Resolution • A designated Complaints Officer is overseeing the management of complaints and ensure compliance with the centre's policy and regulatory requirements. • A structured investigation process has been introduced, including clear timelines for response and resolution. • The outcome of each investigation is now documented and communicated to the complainant in a clear and transparent manner, including any follow-up actions taken. • A monthly review of complaints is conducted by the management team to identify trends and ensure continuous quality improvement. Oversight and Assurance • A complaints audit tool has been introduced as part of audit plan to monitor compliance with the complaints procedure and identify any gaps. • A complaints analysis report is now included in the monthly governance meeting agenda to ensure senior management oversight. • All Staff will have received training on the updated complaints policy to ensure consistent and effective handling of all complaints. Future Assurance • All future complaints will be documented and investigated promptly in line with the revised policy. • A resident and family feedback form been reviewed to provide ongoing input into the complaints process and identify areas for improvement. • Complaints data will be analysed quarterly to identify patterns and ensure proactive improvements in care quality and service delivery. The provider is confident that these measures have established a robust complaints management framework that ensures transparency, accountability, and ongoing compliance with Regulation 34.	

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: A thorough review of the existing care plans has been completed. An update of training for Staff Nurses has been commenced to ensure understanding and application of the assessments are completed in line with best practice. A schedule of review of assessments and care plans with overview by Managers has been designed and implemented	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: To ensure residents have timely access to health care services, the following actions have been taken: • A clinical review process has been introduced to monitor residents' health care needs and ensure timely access to services. • Arrangements are in place for Residents to access their own chosen GP and there is also an on-call GP service available to provide out-of-hours medical support. Should a Resident or family not be satisfied with the medical access further support will be sought with their input. • Partnerships with allied health professionals (e.g., physiotherapists, occupational therapists) have been strengthened to ensure residents receive comprehensive care. • A care pathway has been introduced to ensure timely referral and follow-up for all residents requiring specialist care. The provider is confident that these measures have established a robust management structure with clear lines of accountability and oversight, ensuring high-quality and safe care for all residents.	

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The provider acknowledges the need to strengthen the provision of meaningful activities to ensure they meet the individual needs and preferences of residents, in line with Regulation 9. The following corrective actions have been implemented to provide a structured, measurable, and resident-centred approach to activities and social engagement: Review and Consultation • A full review of the activities schedule has been conducted, with input from residents through one-to-one discussions and residents' meetings to ensure their preferences and interests are reflected. • A resident survey was completed to capture feedback on the types of activities residents wish to participate in, including suggestions for new activities and preferred timings. • The activities schedule has been adjusted based on this feedback to include a wider variety of group and individual activities tailored to the cognitive, physical, and social needs of residents. Provision and Oversight of Activities • A dedicated Activities Co-Ordinator has been assigned to oversee the delivery and quality of activities, with a structured handover process to ensure continuity during planned and unplanned absences. • Key staff members have received training on facilitating meaningful engagement and incorporating social activities into daily care routines as part of the 'household model.' • Activity attendance and resident participation are now recorded more clearly, with monthly reviews to assess engagement levels and identify any gaps in provision and new suggestions sought from Residents to encourage a more varied social experience. Monitoring and Evaluation • A new audit tool has been introduced to monitor the delivery of the activities schedule and ensure it meets the diverse needs of residents. • Resident satisfaction with the activities programme is now reviewed monthly during residents' meetings, with adjustments made based on resident feedback. • A monthly report on activity provision and resident engagement is presented at the governance meeting to ensure ongoing oversight and continuous improvement. Future Assurance and Timeline • A formalised system for reviewing and updating the activities schedule will be implemented within three months to ensure activities remain aligned with residents' evolving needs and preferences. • Resident feedback forums will be held quarterly to ensure the activities programme remains dynamic and responsive. • Staff will receive refresher training on delivering person-centred activities and encouraging social engagement by 30.04.2025.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	21/03/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	21/03/2025

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.	Not Compliant	Orange	30/04/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	21/03/2025
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 resident immediately before	Substantially Compliant	Yellow	21/03/2025

	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	21/03/2025
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	21/03/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	21/03/2025