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:	Alzheimer's Care Centre
Name of provider:	Sparantus Limited
Address of centre:	Highfield Healthcare, Swords Road, Whitehall, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	24 September 2025
Centre ID:	OSV-0000113
Fieldwork ID:	MON-0042212

About the designated centre

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

Alzheimer Care Centre is a 91 bed centre providing residential services to males and females with a formal diagnosis of dementia over the age of 18 years. The centre also contains a unit specific to meeting the needs of people with a diagnosis of enduring mental illness. The centre is located on the Swords Road at Whitehall in Dublin within easy reach of local amenities including shopping centres, restaurants, libraries and coffee shops. The centre comprises of an original single storey building and a large extension over three floors which was opened in 2012. Accommodation for residents is across four units. With the exception of the Grattan unit, the remaining units consist of single bedrooms with fully accessible shower and toilet en suites, dining and sitting rooms and access to safe outdoor garden areas. The centre also contains a large oratory for prayers and religious services, activity rooms, hairdressing salons, coffee dock, several private visitors rooms and designated smoking areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	75

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 24 September 2025	07:05hrs to 16:50hrs	Niamh Moore	Lead
Wednesday 24 September 2025	07:05hrs to 16:50hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

This inspection took place in Alzheimer's Care Centre in Whitehall, Dublin 9. Overall, residents spoken with said they were happy and that they felt safe within the centre. Staff were observed to be familiar with residents' needs and preferences. However, concerns regarding staffing levels were consistently highlighted by residents and some visitors, and was also observed by inspectors' on the day of the inspection.

Inspectors arrived to the centre at 07:00am and following a brief discussion with the night nursing officer who was the manager in charge at the time, completed a walk around the premises. The premises is located on a campus where mental health services and the nursing home residential units are located. The designated centre is registered for 91 residents with 75 residents living in the centre on the day of the inspection. The premises is located across three floors, which were accessible by stairs and lifts. There were four self-contained units, with three of these open for residential accommodation and referred to as Delville/Lindsay, Coghill/Daneswell and Drishogue. The Grattan unit had recently closed and had no residents residing in it at the time of inspection, with plans for this area to be utilised for mental health services in the future. Following this walk around, inspectors met with three members of the management team including the person in charge to complete an introductory meeting.

The centre is registered to provide support to residents with a diagnosis of Alzheimer's disease or Dementia and these residents resided in the Coghill/Daneswell and Drishogue units. Residents who have mental health difficulties and complex physical needs were supported in the Delville/Lindsay unit. Each unit functions as a self-contained unit with residents' bedrooms and dining and sitting room facilities. Accommodation for residents consisted of single bedrooms with en-suite facilities. Bedrooms were clean, and inspectors saw that many residents had personalised their bedrooms spaces with their individual belongings. Residents of the Delville/Lindsay units who had recently moved from the Grattan unit spoke about how happy they were with their new larger sized bedrooms and en-suite facilities.

The centre was clean and well-maintained. The design and layout of the centre was generally suitable for residents' individual and collective needs, however wayfinding on some of the units required improvement as inspectors saw residents experience confusion on how to find and access the communal areas. Shared facilities such as a coffee shop, visiting rooms and a chapel were located on the ground floor of the building and were seen to be used by residents. The coffee shop was a hub of activity on the day of the inspection and residents spoke about enjoying this space. There was also outdoor space available, directly accessible in two out of the three units, which also contained designated smoking areas. These areas contained

suitable fire safety equipment, however the Drishogue smoking area did not have a call-bell, should residents require assistance.

There were information boards which displayed the complaints procedures, advocacy services and other relevant information. Residents' views on the running of the centre were sought through residents' meetings and surveys, and the results of a recent survey was displayed within the centre. There was an activity calendar on display in each unit, however inspectors found that activity schedules were not accurate on the day of the inspection. For example, an activity facilitated by a volunteer in the Delville/Lindsay unit was not recorded on this schedule, and due to the absence of the activity coordinator, residents were unaware of what activities were scheduled in this unit on the day of the inspection.

Inspectors observed that the majority of interactions of staff supporting residents on the day of the inspection were kind and respectful towards residents. Overall residents told inspectors they were happy with the care provided and were "well looked after". However, some residents and visitors spoken with stated they felt there was not enough staff. One resident said they felt staff were over worked and another explained that they required assistance of two staff and there were delays in the availability of the second staff member to support their needs in a timely manner. This was also reflected in family feedback relating to staff availability to assist with timely entering and exiting of the individual units.

Inspectors observed the lunch-time meal being served on the day of the inspection. There was a choice of beef stew or roast chicken, and a vegetarian option of cauliflower and chickpea curry. Most residents were observed eating their meals in the communal areas, and a tray service was also available for residents who wished to take their meals in their bedrooms. Feedback received from residents was that they enjoyed the meals on offer. While inspectors observed staff supporting residents in a patient and kind manner, the dining experience for some residents receiving their meals in the sitting rooms did not uphold residents' rights, and this will be further discussed within this report.

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

Capacity and capability

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). On this inspection, the inspectors also followed up on the compliance plan from the last regulatory inspection and information, both solicited and unsolicited, received since then. Inspectors found that overall the management systems in place required strengthening to ensure that all residents

received a service that was safe, appropriate, consistent and effectively monitored, particularly in the areas of staffing levels, supervision of staff, documentation, oversight, the notification of incidents and complaints procedures. Findings under the theme of Quality and Safety, are further discussed within this report.

Alzheimer's Care Centre is operated by Sparantus Limited. One of the eight company directors with the role of Medical Director is the person delegated by the provider with responsibility for senior management oversight of the service. The management structure supporting the designated centre comprised of a Chief Executive Officer and a Director of Clinical Operations, both of whom were persons participating in the management of the service and provided support to the person in charge.

Inspectors found that at the time of the inspection, the registered provider was not operating in compliance with the Health Act 2007. The registered provider was in breach of Condition 1 of their registration, as the required staffing levels set out in this condition were not adhered to. While the registered provider had submitted to the Chief Inspector of Social Services an application to vary Condition 1 to reduce staffing levels, and Condition 3 to reduce the occupancy, following the closure of the Grattan unit, this application was still being processed by the Chief inspector. In addition, there had been multiple engagements between the Office of the Chief Inspector and the registered provider, during which the provider was informed that a reduction in staffing levels had not been agreed.

The person in charge worked full-time within the centre and was supported in their management role by a Clinical Nurse Manager grade 3 and three Clinical Nurse Managers grade 2. Staff were allocated by unit and these allocations included nurses, senior health care assistants, health care assistants, activity staff and housekeeping staff. In addition, the centre was supported with personnel from catering, maintenance and administration. Inspectors were told that recruitment was ongoing for posts such as healthcare assistants, occupational therapists and activity therapists. However, inspectors were not assured that there was a sufficient number and skill-mix of staff to meet the assessed needs of residents. This is further discussed under Regulation 15: Staffing.

Staff were supported to attend mandatory training on topics such as safeguarding vulnerable adults from abuse, infection control and manual handling. A training plan was developed to ensure that all staff were up-to-date with their training, particularly in the area of fire safety.

A sample of formal supervision records were reviewed, this included staff induction records and annual appraisals. There were systems in place to identify and support staff who required additional supervision to ensure they were knowledgeable and effective in their roles. However, inspectors were not assured that the arrangements for clinical supervision were sufficiently robust. This is further discussed under Regulation 16: Training and staff development.

While many records were provided to inspectors for this inspection, not all of the required records as required by the regulations, were made available or were easily

retrievable. This resulted in delays during the inspection, as numerous documents had to be repeatedly requested. A further written request for the outstanding information was issued to the provider following the inspection. This is further discussed under Regulation 21: Records.

There were clear roles and responsibilities established within the management structure that identified the lines of authority and accountability for all areas of care provision. Some management oversight systems were in place which included meetings, committees and auditing. However, inspectors found that these systems did not always identify areas that required improvement, and in some cases despite improvements being identified they were not fully actioned. As a result, there was a reduction in compliance across a number of regulations on this inspection. This is further discussed under Regulation 23: Governance and Management.

Following a review of the complaints register, a number of incidents had not been recognised as safeguarding concerns and therefore the relevant notifications had not been submitted to the Chief Inspector.

There was a complaints procedure in place dated February 2024 which outlined the management of complaints within the centre, including the designated personnel and expected timeframes. This procedure was displayed in prominent positions within the centre. Inspectors saw there was evidence that complaints were recorded, investigated and concluded as soon as possible; however training records for the nominated complaints officer and review officer were not available at the time of inspection. This and other gaps are further outlined under Regulation 34: Complaints Procedures.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

An application to vary condition 1 and 3 of the centre's registration had been received, and was under review at the time of this inspection.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that there was a sufficient number and skill mix of staff available within the designated centre to meet the assessed needs of the 75 residents in accordance with Regulation 5, and the size and layout of the designated centre. For example:

- 95% of residents in the Coghill/Daneswell unit were assessed as being of maximum or high dependency. From reviewing the staffing rosters it was evident that the staffing levels for this unit set out within Condition 1 were

not adhered to. Inspectors found evidence of insufficient staffing levels of this unit. For example, there was a delay in morning care provision with inspectors observing that some residents were supported out of bed at lunch-time. In addition, on this unit there was a delay in the serving of the lunch-time meal on the day of the inspection. Residents and visitors also confirmed that there were many occasions where staff shortages adversely impacted residents' quality of care.

- There was a vacancy for an activity coordinator in the Delville/Lindsay unit since July 2025 which was not fully covered and as a result there was a reduction in residents' social needs of this unit being met. This is further discussed under Regulation 9: Residents' rights.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff supervision and oversight was insufficient as evidenced by:

- While a hoist and sling checklist had been introduced as part of a manual handling quality improvement plan, the oversight of this checklist was ineffective. Not all members of the management team were aware of its implementation, and a sample of records reviewed indicated gaps in adherence to the checklist.
- There was ineffective supervision of staff and lack of clear guidance to ensure that care interventions based on assessments and care plans were provided to residents. For example, inspectors observed on the Drishogue unit an instance where a resident was not supported to get up from their chair and walk, despite their care plan specifying this as their preference.

Judgment: Substantially compliant

Regulation 21: Records

The provider had not ensured that all records were available to inspectors on the day of the inspection. As a result, many outstanding documents set out in Schedules 2, 3 and 4 were required to be submitted the day following this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that the centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose:

As evidenced under regulation 15, the staffing levels in Coghill/Daneswell unit were not sufficient to meet residents' assessed individual needs. The Chief Inspector of Social Services had agreed with the registered provider the minimum staffing levels for each unit and Condition 1 of the registration required the registered provider to adhere to those staffing levels. This inspection found that the provider had not complied with this condition.

The management systems in place did not fully ensure that the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by the following findings:

- Analysis of information through incidents occurring within the designated centre did not always lead to quality improvements and outcomes for residents. For example, identified learnings from a serious incident review had not been fully implemented on the day of the inspection. Although a new initiative had been developed, gaps were observed in both the documentation and oversight of this measure.
- The oversight of residents' dining experience did not ensure that all residents had a dining experience which upheld their rights and dignity. Residents in the Coghill/ Daneswell unit did not have the same dining experience as residents in the other units. Meals in this unit were served in an area which is also used as a day space, which resulted in residents eating their meals from armchairs and bed side tables. Consequently, residents did not have the opportunity to engage socially at a dining table with other residents and staff during their meals.
- There was poor oversight and management of records which were required to be available as part of this inspection.
- Oversight systems for the submission of notifications to the Chief Inspector were not effective.
- Notwithstanding the good systems in place to safeguard against the risk of fire, including regular fire drills, the inspectors found that relevant scenarios had not been trialled. For example, no fire drill had been conducted to simulate a scenario in which residents locked their bedroom doors. During this inspection, inspectors observed that a high proportion of residents in one unit preferred to lock their doors. As this scenario had not been tested, there was insufficient assurance regarding the safe evacuation of this unit.

An annual review of the quality and safety of care delivered to residents in the designated centre for the period of April 2024 to March 2025 was completed, with a quality improvement plan developed, however some areas did not have a timebound plan to address all issues identified.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not submitted to the Chief Inspector three notifications of safeguarding incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

The designated centre's annual review provided information on complaints received, however the level of engagement of independent advocacy services with residents was not included. While the report and the registered provider's policy stated that all staff involved in handling of complaints undertook training, evidence was not provided to inspectors on this training.

Judgment: Substantially compliant

Quality and safety

Overall residents appeared happy living in the centre and had good access to health care services. However, action was required to ensure a safe and good quality service for all residents, particularly in the areas of care planning, residents' rights, risk management and fire precautions.

Care records were not consistent on all units. Inspectors found that regulatory timeframes had been met and that some assessments and care plans sufficiently guided care, however, action was required to ensure that all care plans were individualised and reflected each individual's health and social care needs. This is further outlined under Regulation 5: Individual assessment and care plan.

Residents had timely access to medical assessments and treatment by their general practitioner (GP), who visited the centre on a daily basis. Access to specialised services such as psychiatry of later life and palliative care were available through a referral system. Residents' records showed that residents had access to services such as occupational therapy (OT) and physiotherapy. Inspectors were also informed that eligible residents were facilitated to access the services of the national screening programme.

There was a safeguarding policy in place, and staff had completed safeguarding training to ensure they were aware of what to do if they suspected any form of abuse.

Residents had access to advocacy services which were on display in the centre and residents were consulted about the service through residents' meetings and surveys. Residents also had access to the radio, newspapers and television. However, inspectors found that the provision of activities was impacted by staffing gaps in activity personnel. In addition, while the majority of interventions were observed to uphold residents' rights there were occasions where residents' rights to dignity and privacy were not upheld and this is further discussed under Regulation 9: Residents' rights.

The premises was well-maintained by a team of maintenance personnel; for example painting was ongoing during this inspection, and environmental audits highlighted areas which required attention. The management of the environment assisted with ensuring good infection control measures. The centre had a specific cleaning policy, however this required updating.

The registered provider had a risk management policy which was dated March 2024 and outlined the risk management processes for the designated centre. However, this policy had not been updated with the requirements of the new regulations, and is further discussed under Regulation 26: Risk management.

The registered provider had ensured there was suitable fire fighting equipment and maintenance of the equipment in place. While fire drills were routinely occurring every three months, these drills did not reflect all scenarios and this is further discussed under Regulation 23: Governance and Management.

Regulation 17: Premises

The premises was appropriate for the number and needs of the residents.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy in place did not outline the following:

- The measures and actions in place to control the risk of infectious diseases
- The arrangement for the identification, recording and investigation of serious incidents or adverse events involving residents, including a process for the implementation of actions and recommendations from this review

- A process for audit, review and learning from events.

Judgment: Substantially compliant

Regulation 27: Infection control

There were sufficient resources for housekeeping on the day of the inspection, and the centre was clean. Staff were supported to attend infection control training.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had some good fire safety processes in place. For example, a competent person had completed a fire safety risk assessment and the registered provider was responding to the actions identified for completion.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Not all care plans, reviewed on the day of inspection, had been revised to reflect the current assessed health, personal or social care needs of the resident. For example:

- A safeguarding care plan reviewed, had not been updated following the findings of a safeguarding investigation.
- Care plans were not always updated following incidents. For example, a resident who had a recent fall and a resident who had a recent event of unexplained absence, did not have their care plans updated.
- Some care plans were generic and contained information which was copied and pasted, and did not provide specific measures to support the residents' individual needs.

This created a risk that staff were not guided on current and appropriate care needs of the residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate medical care including a range of allied health care professionals such as physiotherapy, occupational therapy, dietitian, and speech and language therapy.

Judgment: Compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to protect residents from abuse. Staff who spoke with inspectors were knowledgeable on how to protect residents from harm and putting their safeguarding training into practice.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider did not provide opportunities for all residents to participate in activities in accordance with their interests. For example, the activities provided on the day of inspection did not provide meaningful engagement with the residents, particularly for the Delville/Lindsay unit as there was no activity coordinator in place. Inspectors saw there were gaps in the record of activities occurring within this unit, and residents on this unit told inspectors that they would like more activities and recreation to take place.

Inspectors observed three occasions where staff practice and the environment did not promote residents' rights to choice. For example:

- Residents were impacted by the available space for meals provided in the Coghill and Daneswell units. As discussed earlier within this report, some residents were sitting in arm chairs in day-rooms to have their lunch-time meal, meaning these residents did not have access to the same dining experience as other residents who sat at dining tables and chairs in the dining room on other units.
- On two occasions, a resident who was trying to get up from their chair was told to sit back down by care staff.
- In addition, a resident who was looking to find the day-room in one unit was not supported to locate this area by staff.

Residents in the centre did not have their privacy and dignity in their bedrooms maintained at all times. For example, there were windows in resident's bedroom

doors that were controlled by a mechanism on the outside of the door. This allowed for the view into a resident's room to be obscured. However, due to its location on the outside of the door the residents had no control over it and anyone on the corridor could open or close this mechanism at any time. This is a repeat finding and in addition, during this inspection inspectors observed that some of these mechanisms were broken.
Judgment: Not 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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Alzheimer's Care Centre OSV-0000113

Inspection ID: MON-0042212

Date of inspection: 24/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Increased staffing levels Following the inspection, the registered provider immediately restored all staffing levels to meet Condition 1 of Registration, and all units — including Coghill/Daneswell — are now fully aligned with the minimum staffing requirements agreed with the Chief Inspector. The provider commits that no reduction in staffing levels will occur unless formally approved by the Chief Inspector through a varied Condition 1. Person Responsible: PIC /CNM3 /CNM2 Timeframe: Completed/Implemented Appointment of Activity Coordinator The vacancy on Dellville/Lindsay has been filled, ensuring residents' social and recreational needs are fully met. Person Responsible: Registered Provider /PIC Timeframe: Completed	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Oversight of Manual Handling Quality Improvement • The HCA Team Leader now conducts daily checks on the hoist and sling checklist. • CNM2 completes a weekly audit to ensure adherence and to address any gaps	

immediately.
• All nurse managers have been briefed on expectations and are accountable for compliance.

Person Responsible: PIC /CNM3/CNM2
Timeframe: Completed/Implemented

Supervision System Strengthened
A structured supervision framework has been implemented, including:
• Supervision rounds on every shift
• A monthly audit of supervision records
• Immediate correction of any deviation from care plans

Person Responsible: PIC/CNM3
Timeframe: Completed, communication protocol ongoing for all future initiatives.

Guidance for direct care interventions
The CNM1 and/or nurse in charge conduct supervision rounds on every shift to ensure care interventions outlined in the care plan are being carried out. Any deviations from the care plans are addressed immediately and used to inform reflective practice or targeted supervision.

Person Responsible: PIC/CNM3 /CNM2 /CNM1/Nurse in Charge
Timeframe: Completed/Implemented

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Records Management System
• All Schedule 2, 3 and 4 records are now complete, available, and were submitted to the Chief Inspector following the inspection.
• A central indexed records system (paper and electronic) allows immediate access for inspectors.
• A dedicated laptop and login will be provided instantly to inspectors on arrival which will provide access to digital records.

Person Responsible: PIC/CNM3
Timeframe: Completed/Implemented

Regulation 23: Governance and management	Not Compliant

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

Staffing

As outlined under Regulation 15, staffing levels have been fully restored to comply with Condition 1.

Person Responsible: PIC /CNM3 /CNM2

Timeframe: Completed

Learning from Incidents:

• All learning from incident reviews is now incorporated into the service-wide Quality Improvement Plan, with clear owners and timelines.

• The HCA Team Leader completes daily checks; CNM2 conducts weekly audits.

• A weekly safeguarding and incident oversight meeting has been introduced.

Person Responsible: PIC /CNM3/CNM2

Timeframe: Completed

Dining Experience for the residents

To address inspectors' findings regarding dignity and rights:

• The activity room is being converted into a dedicated communal/activity space.

• A new dedicated dining room is being established to ensure all residents dine at tables in a dignified environment.

• Regular walkabouts by PIC and CNMs ensures equity of dining experience across units and to provide oversight.

Monitoring and Evaluation

The PIC and Clinical Nurse Managers will continue to conduct regular walkabouts during mealtimes to ensure the new arrangements promote dignity, rights, and choice.

Person Responsible: PIC

Timescale: 31Dec25

Records Oversight:

As outlined under Regulation 21, records are now centralised and immediately accessible.

Person Responsible: PIC/CNM3

Timeframe: Completed

Review of Incidents

A full review of six months of incidents has been completed to ensure no further omissions. Every complaint is now screened for potential safeguarding concerns and escalated when required.

Person Responsible: PIC /Complaints Officer /Safeguarding Lead

Time frame: Completed/Implemented

Fire Drills

A drill simulating the locked-bedroom-door scenario in Drishogue has been completed.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Review of Incidents
A retrospective review has been completed to identify any missed notifications.
A new process ensures:
• All incidents are screened for safeguarding potential
• Notifications are submitted to the Chief Inspector within 2 working days
• Weekly safeguarding/incident oversight meetings maintain compliance

Person Responsible: PIC /Complaints Officer /Safeguarding Lead
Time frame: Completed/Implemented

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Advocacy Documentation
Engagement with independent advocacy services will be recorded for every relevant complaint

Where advocacy is not involved, this will also be documented.
Advocacy involvement to be monitored for compliance and statistics of advocacy involvement to be included in the next annual review 1Apr25 – 31Mar26
Person Responsible: PIC /Complaints Officer
Time frame: Statistics will be in the annual review 1Apr25 – 31Mar26. Engagement activity implemented.

Complaints Handling Training
All relevant staff have now completed complaints training. HR maintains an updated log.

Person Responsible: PIC /CNM3 /HR
Time frame: Completed.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Corrective Action
The risk management policy has been updated to include:
• Infection control risks
• Serious incident investigation
• Implementation of recommendations

• Audit, review and learning frameworks
The updated policy has been circulated to all staff and reviewed at governance meetings.

Person Responsible: PIC /Head Of Quality
Time frame: Completed.

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:
Corrective Action
Care plan audits have been completed and corrective actions taken. Going forward:
• Quarterly audits will ensure full compliance with four-monthly review cycles
• Post-incident care plan updates are now monitored through the audit process

Person Responsible: PIC/CNM3/CNM2
Timeframe: Completed / Implemented

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Appointment of Activity Coordinator
The activity coordinator position has been filled.
A monthly activities audit tool is now in place to ensure meaningful engagement on all units
Person Responsible: Registered Provider /PIC
Timeframe: Completed

Dining Experience
As outlined under Regulation 23, dedicated dining and activity spaces are being established.
Person Responsible: PIC
Timeframe: 31Dec25

Wayfinding:
OT has reviewed all unit's, and signage has been enhanced.
Person Responsible: PIC/Occupational Therapist
Timeframe: Completed

Monitoring and Evaluation
The PIC and Clinical Nurse Managers will continue to conduct regular walkabouts during mealtimes to ensure that residents rights, choice and dignity are upheld.

Person Responsible: PIC
Timescales: Implemented

Privacy Screens
Following resident consultation, privacy film/screens will be applied to ensure dignity. The PIC will carry out a final walkthrough post-installation.

Person Responsible: PIC /Maintenance Department
Time frame: 31Dec25

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	26/11/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	26/11/2025
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	26/11/2025
Regulation 23(1)(a)	The registered provider shall	Not Compliant	Orange	26/11/2025

	ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/12/2025
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e).	Substantially Compliant	Yellow	26/11/2025
Regulation 26(1)(c)(vi)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control infectious diseases.	Substantially Compliant	Yellow	26/11/2025
Regulation 26(1)(d)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	26/11/2025

	policy set out in Schedule 5 includes arrangements for the identification, recording and investigation of serious incidents or adverse events involving residents.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the implementation of actions and recommendations arising from subparagraph (d).	Substantially Compliant	Yellow	26/11/2025
Regulation 26(1)(f)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the audit, review and learning from events.	Substantially Compliant	Yellow	26/11/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	26/11/2025
Regulation 34(6)(b)(i)	The registered provider shall ensure that as part	Substantially Compliant	Yellow	30/04/2026

	of the designated centre's annual review, as referred to in Part 7, a general report is provided on the level of engagement of independent advocacy services with residents.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	26/11/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	26/11/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with	Not Compliant	Orange	26/11/2025

	their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/12/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	31/12/2025