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:	Lawson House Nursing Home
Name of provider:	Lawson House Nursing Home Limited
Address of centre:	Knockrathkyle, Glenbrien, Enniscorthy, Wexford
Type of inspection:	Unannounced
Date of inspection:	08 May 2025
Centre ID:	OSV-0000244
Fieldwork ID:	MON-0041391

About the designated centre

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

Lawson House Nursing Home is a single storey, purpose built nursing home which was opened in 1996 and had most recently been extended in 2011. It can accommodate up to 65 residents and the accommodation consists of 57 single bedrooms with ensuite facilities of shower, toilet and wash hand basin, six single bedrooms with shared bathroom inclusive of shower, toilet and wash hand basin and two single bedrooms with a wash hand basin. The external grounds were adequately maintained and residents had free access to a safe secure garden. There are multiple communal rooms strategically situated throughout the centre for resident use. The provider is a limited company called Lawson House Nursing Home Ltd. The centre is located in rural setting close to the village of Glenbrien, near Enniscorthy, Co Wexford. The centre provides care and support for both female and male adult residents aged 18 years and over. Care is provided for residents requiring varying levels of dependency from low dependency up to maximum dependency care needs. The centre provides care for long term residential, respite and, convalescence care, for people with cognitive impairment, such as, those living with a dementia. The centre does not accept admissions of residents under 18 years of age, residents with an active tracheostomy or residents with severe challenging behaviours. Pre-admission assessments are completed to assess a potential resident's needs. Following information supplied by the resident, family, and or the acute hospital, arrangements are made to ensure that all the necessary equipment, knowledge and competency are available to meet the individual needs, and admission date is then arranged. The centre currently employs approximately 73 staff and there is 24-hour care and support provided by registered nursing and health care assistant staff with the support of housekeeping, catering, administration, laundry and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 8 May 2025	09:00hrs to 17:55hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

The inspector greeted and chatted with residents in the centre to gain an insight into their lived experiences in the centre. In general, residents spoken with said they are happy living in Lawson House Nursing Home. However, one resident spoken with said they were not happy residing in the centre. The inspector also spent time in the communal areas observing resident and staff engagement. There was a friendly atmosphere in the centre and staff and resident interactions were observed to be kind. The residents were complimentary of the staff and described them as 'good', 'very caring' and 'very kind'. Improvements were observed with residents' rights since the last inspection, for example, staff were observed to offer residents a choice of when they wanted to get up in the morning. A resident spoken with said they 'loved' being in the centre and 'loved the freedom'. While residents had praise for staff they spoke about extended waiting times for care and attention, with one resident saying they have pressed the emergency call bell to get a timely response for assistance on an occasion. Similar to the last inspection, some residents also described their concern with other residents coming into their rooms and moving their belongings.

The inspector had an opening meeting with the clinical nurse manager (CNM) and was later joined by the assistant director of nursing (ADON), in the absence of the person in charge. On the day of inspection, the person in charge, director of nursing (DON) and ADON were not scheduled to work. However, the DON and ADON arrived to the centre later that morning. Following the opening meeting, the DON and ADON accompanied the inspector on a tour of the centre. The centre is set out over one floor and divided into four different units referred to as; the Slaney, Suir, Nore and Barrow.

The centre can accommodate a maximum of 65 residents, with one vacancy on the day of inspection. Resident accommodation is located in each of the four units and all bedrooms are single occupancy, of which, 57 have an en-suite and the remaining bedrooms have access to communal bathroom facilities. Residents' bedrooms were personalised with items of memorabilia and some items from home. Throughout the day, residents who remained in their bedrooms at different times were seen to have a call bell within reach should they require assistance.

The centre's design and layout supported residents' free movement and comfort, with wide corridors and sufficient handrails throughout the centre. Residents could also freely access each unit if they wished. Overall, the centre was clean and bright with a relaxed atmosphere. However, some of the seating in some communal areas was not suitable for residents comfort and use. For example, some chairs were too low for residents use, some seating consisted of office chairs or dining table chairs and some seating was damaged.

Communal space consisted of four lounge areas; one in the Suir, Nore and Barrow units. Throughout the day of inspection these rooms were not in use by residents

and had limited decoration which impacted how inviting these rooms were. There was a large lounge referred to as the garden lounge, where large group activities took place and where residents were observed to be located for the majority of the day. There was also a library which was used for smaller group activities. A cinema room in the centre had been converted into an oratory on the day of inspection and was not accessible to residents due to maintenance works being carried out. Residents also had a large open dining room, a sensory room and a smoking room. There was also a long wide corridor which led onto the Suir, Nore and Barrow units where residents were also observed to be seated at times while looking out onto the garden area.

The inspector observed that the registered provider had made changes to the footprint of the centre that were additional to the proposed changes in the application to vary condition 1 of registration. An activity office had been changed to ADON office. The family over-night room has an en-suite toilet, and an additional room attached to the cinema room which were not included in the statement of purpose.

Outdoors, the centre had a large, secure internal garden off the garden lounge, which could also be accessed from several corridors throughout the centre. The garden was landscaped, with features including flower beds, shrubs, and a pergola. Some maintenance was required in the garden as there were some gaps in the stone paving which could be a trip hazard. In addition, the pathways in the garden and on the fire exit pathway from the dining room had weeds growing and debris which could pose a risk to residents, in particular on the fire escape route.

There was an activity schedule displayed on a large notice board in the centre. Since the last inspection another activity staff had been recruited and residents reported improvements in the activities available to them. Residents' spoke about enjoying the external singers and music, which attended the centre each weekend, in particular. On the morning of inspection, Mass was on television for residents in the garden lounge while others watched Mass in their bedrooms. After Mass a large group of residents played snakes and ladders together. In the afternoon residents attended an exercise class, following this, a small group of residents played bingo while a larger group of residents were watching a movie and chatting with staff. Overall, the majority of residents spoken with said the enjoyed the activities. However, one resident said they did not like the activities and found it 'boring' in the centre.

The inspector observed the mealtime in the dining room on the day of inspection as a sociable and relaxed experience, with residents chatting together and staff providing discreet and respectful assistance where required. Meals were severed in two sittings, with other residents choosing to eat in their bedroom, which was their preference. Food was prepared in the kitchen in the centre and served from a bain-marie. Each table was nicely set and had a menu for residents to choose from, with two dinner options available to them. Residents' were also offered a variety of drinks available to them to choose from. There was mixed feedback from residents about the food with one residents saying the food was 'excellent' and another resident saying the food was 'dreadful'. Other residents spoken with said the food was okay

and expressed their views that there was a lack of variety of food, in particular for the evening meal and that the temperature of food was sometimes cold. Feedback from a recent resident survey also reflected similar views from residents who said the food required improvements, including the temperature of food.

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 the quality and safety of the service being delivered.

Capacity and capability

There were established management structures in place in the centre, with key roles identified within the management team to oversee the operation of the centre. While there were some good practices identified, the inspector found that some improvements were required to ensure all aspects of the service met residents' needs, and were in line with the regulations. This included ensuring the effective oversight of staffing arrangements and resources, individual assessment and care planning, premises, fire precautions and personal possessions.

This unannounced inspection was carried out over one day by an inspector of social services. The purpose of this inspection was to assess compliance with regulations, review the registered provider's compliance plan following the previous inspection and to inform a decision on an application to vary condition 1 of registration for the centre, which was under review. The inspector also reviewed the information submitted by the provider and the person in charge in advance of the inspection.

The registered provider is Lawson House Nursing Home Limited. The person in charge was also a company director and worked three days in the centre. However, the statement of purpose detailed the person in charge as working full-time in the centre. They were supported in their role by support services manager, who was also a company director, a full-time director of nursing (DON), a part-time assistant director of nursing (ADON) and two full-time clinical nurse managers (CNMs). The person in charge also had oversight of a team of staff nurses, healthcare assistants, activity co-ordinators, catering, domestic, administration and maintenance staff.

There was a meeting schedule in place for management meetings, multi-disciplinary meetings, staff meetings and quality and safety meetings. Meetings were held regularly and minuted to cover all aspects of clinical and non-clinical operations. Management meetings covered areas such as, outbreaks of infection, fire safety checks, call bells, staffing, trending of falls and notifications, restrictive practices, incidents, complaints. Information in these meetings was trended with time bound actions identified and a person responsible for completing these. The provider also had audit and monitoring systems in place to oversee the service, which were also discussed a management meetings. However, actions identified did not always drive quality improvement. For example, delays in call bell response times had been discussed on a number of occasions since January 2025. A call bell audit was also

completed, however, findings from the inspection evidenced continued delays in call bell response times.

An annual review of the quality and safety of care delivered to residents had taken place for 2024, with an action plan in place for further service improvement and development for 2025. It was evident that residents had been consulted in the preparation of the annual review through a residents' satisfaction survey, residents meetings and the residents suggestion box.

The previous inspection in November 2024 had identified that a review of staffing was required to ensure a sufficient number and skill mix to meet the assessed needs of residents. In particular, for a small number of residents with complex needs and for activity provision. Additional activity staff were in place in the centre on the day of inspection, which had enhanced the activity provision for residents in the centre. The number of residents with complex needs had also reduced. While these improvements were observed, the inspector found that the number and skill mix of staff regarding the needs of residents did not ensure that the needs of residents were being met. Feedback from residents and visitors detailed delays with having their care needs met. The inspector also observed complaints made about delays in calls bells being responded. Additionally, call bell reports reviewed by the inspector showed that some residents had to wait up to 21 minutes for staff to respond to the call bell to attend to their care needs.

Improvements were observed in the notification of incidents since the last inspection, with all notifiable incidents having been notified to the Chief Inspector.

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

An application to vary condition 1 of registration of the designated centre in accordance with the requirements set out in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 had been made by the registered provider. This application was in the process of being reviewed at the time of inspection.

During the inspection, the inspector identified that the registered provider had made changes to the centre, which were not included in the application. For example, an additional room was built onto the cinema room, there was an en-suite in the family over-night room and the activity office was changed to an ADON office.

Judgment: Substantially compliant

Regulation 15: Staffing

Following on from the last inspection, a further review was required of the number and skill mix of staff having regard to the needs of the residents and the size and layout of the designated centre to ensure effective delivery of care. The findings of this inspection were that:

- Residents told the inspector that sometimes they had to wait for a prolonged period of time before they received the care requested. For example, some residents reported having to wait up to 30 minutes for staff to attend to them after using the call bell to seek assistance. One resident said that they sometimes turn off their call bell as they have been waiting a prolonged period of time and press the emergency call bell to get a staff response. Some family members spoken with similarly said that staff were 'slow' to respond to residents when they need assistance.
- The centre had also received three complaints about delays in care being provided. For example, residents waiting a prolonged period of time for staff to assist them to go to the toilet and delays in call bells being responded to.
- On a review of records for the call bell system there were 10 examples of residents waiting for 10 to 21 minutes for assistance.

Judgment: Not compliant

Regulation 21: Records

A sample of staff files reviewed by the inspector were found to be well-maintained. These files contained all the necessary information as required by Schedule 2 of the regulations, including the required references and qualifications. Evidence of active registration with the Nursing and Midwifery Board of Ireland was also seen in the nursing staff records viewed.

Judgment: Compliant

Regulation 23: Governance and management

While the registered provider had several assurance systems in place to monitor the quality and safety of the service provided, the auditing system was not fully effective in identifying risks and driving quality improvement. For example:

- Call bell audits were completed and identified delays in response times to residents requesting assistance. Call bell response times and call bell audits had been discussed a several management meetings since January 2025, however, the action plan in place did not drive quality improvement or effect change to ensure residents received timely responses to request for care and attention.

- The oversight systems for monitoring care planning did not ensure that each resident had an up-to-date care plan to meet their identified needs, as discussed under Regulation 5: Assessment and care plan.
- The registered provider had not taken adequate precautions by means of fire safety management and fire drills to ensure that staff working in the centre were aware of the procedure to be followed in the case of a fire. This is detailed in Regulation 28: Fire precautions.

A review was required to ensure that the registered provider had allocated sufficient resources for effective delivery of care. This is detailed under Regulation 15: Staffing. In addition, the designated centre did not have sufficient resources in accordance with the statement of purpose. For example, the person in charge was documented as one whole-time equivalent in the statement of purpose. However, on a review of rosters the person in change worked three days in the centre or 0.64 whole-time equivalent.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents, as set out in schedule 4 of the regulations, were notified to the Office of the Chief Inspector within the required time frames.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were available to inspectors and to staff for review. They had all been updated to reflect the practices and procedures in the centre at intervals not exceeding three years.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider was, in general, delivering a good standard of nursing care; however, the gaps in oversight and resources, as mentioned above, impacted on the quality of life for some residents. Some improvements were observed in relation to resident's rights and managing behaviour that is challenging. Notwithstanding these improvements, some further

actions were required concerning individual assessment and care planning, personal possessions, fire precautions and premises.

The person in charge had arrangements for assessing residents support needs before admission into the centre. Comprehensive person-centred care plans were based on validated risk assessment tools. These care plans were reviewed at regular intervals, not exceeding four months. However, care plans were not always updated as required, for example, following an incident.

Following on from the previous inspection in November 2024 improvements were observed for residents who were in titled-back seating. All residents had been referred to occupational therapy (OT). Five residents had been seen by an occupational therapist and had new equipment in place. Nine residents were still waiting to be seen by OT. During the inspection, residents in the titled chairs did not present as agitated and they were not placed into a tilted position that was restrictive. Residents who had 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) had care plans in place. Some care plans were detailed and individualised. However, similar to the last inspection, some care plans did not detail a person-centred approach to providing care, this is discussed in Regulation 5: Individual assessment and care plan.

The inspector observed improvements in residents being able to exercise choice over their daily routine. The inspector observed staff knocking on residents bedroom doors and requesting to enter. In the morning, it was also observed that staff were asking residents if they wanted to get up and ready for the day, at a time of their choosing. One resident who spoke with the inspector, spoke about loving their freedom there and being able to do what they want. There was an activity schedule in place and the vacant activity staff post had been filled. Residents spoken with also said they enjoyed the activities and it was observed that there was more meaningful activation on the day of inspection.

Details for independent advocacy services were available to residents' and posters with their contact information were displayed throughout the centre. Residents has access to daily national newspapers, weekly local newspapers, Internet services, books, televisions, and radio. Regular residents meetings were held to gain residents input into the organisation and residents surveys were also completed to gain further feedback from residents.

Residents were supported to retain control over their personal property, possessions and finances. Their clothes were laundered regularly and returned to the residents without issue. Residents' had adequate space to store their personal belongings. However, some residents said they personal belongings were not safe due to other residents entering their room.

In general, the premises' design and layout met residents' needs. The centre was bright and had a welcoming atmosphere. While the premises of the designated centre were appropriate for the number and needs of residents and seen to be generally well-maintained internally, some areas required attention to fully comply

with Schedule 6 requirements. In addition, some action was required in relation to premise to ensure that it was in accordance with the statement of purpose.

The inspector reviewed the arrangements at the centre to protect residents from the risk of fire. There was a fire safety policy in place, and each resident had a personal emergency evacuation plan (PEEP). All staff had received fire safety training, however, six staff were due refresher training. This was scheduled to take place the following week after the inspection. Fire evacuation maps and the centre's evacuation procedure were displayed in all compartments throughout the centre. Records reviewed showed that preventive maintenance of fire detection, emergency lighting, and fire fighting equipment was conducted at recommended intervals. There was a designated smoking room in the centre which had the necessary protective equipment, including a call bell, fire blanket, fire extinguisher and fire retardant ashtray. Some areas of improvements were required in relation to fire safety to ensure adequate precautions were in place, which included fire drills, maintenance of escape routes and systems for fire safety checks.

Regulation 12: Personal possessions

While there was adequate space to store residents personal belongings, some residents spoken with said they had issues with other resident entering their room and taking or moving items. One resident spoken with said their belongings were 'never safe'. Another resident spoken with said they often come back to their room to find items moved or removed. This is similar feedback from residents from the last inspection. Residents also have raised this issue at residents meetings, and had requested keys to lock their bedrooms. However, they were directed to ask staff to lock their room for them. One resident said this was not a valid solution due to the delays in staff responding to call bells when assistance was required.

Judgment: Substantially compliant

Regulation 17: Premises

Some improvement were required by the provider to ensure that the premises were appropriate to the number and needs of the residents of the designated centre and in accordance with the statement of purpose prepared under Regulation 3. For example;

- Attached to the cinema room was an additional room which had been previously used to facilitate visits during the Covid-19 pandemic; this was not on the floor plans.
- Within the family over-night room there was an en-suite, which was not included on the floor plans.

Some areas required review to ensure the provider also complied with Schedule 6 of the regulations. For example:

- The registered provider did not ensure that the premises had appropriate and comfortable seating for residents in some communal areas. For example, in two of the lounges and the library some seating was observed to be too low for the use of residents, office chairs and dining room chairs were is use and some seating was damaged.
- Some maintenance was required in the garden as there was some gaps in the stone paving which could be a trip hazard. The pathways in the garden and on a fire exit pathway from the dining room also required maintenance as there were weeds and debris which could pose a risk to residents.
- A cinema room in the centre had been converted into an oratory on the day of inspection was locked due to maintenance works being carried out, meaning it was not accessible to residents.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvement was required of the registered provider to ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable and residents, are aware of the procedure to be followed in the case of a fire. For example, while fire drills were being undertaken, these were not in line with the fire drill policy in the centre. They did not ensure that some drills were conducted to simulate night time conditions to ensure there are sufficient staff to evacuate residents safely.

There was a system for daily and weekly checking of means of escape, fire safety equipment and fire doors, however, gaps were identified in daily checks of fire doors and fire exit routes. For example, there was no record of any checks completed in May 2025 available to the inspector on the day of inspection. Additional gaps were identified in April 2025 also. The centre's policy for fire safety also did not give clear direction to staff on these requirements. In addition, checks did not record any issues, however, some pathways required maintenance to ensure they were free from debris and did not potentially impacted escapes routes in an emergency.

On the day on inspection a fire engineer was servicing equipment, several notifications had been received by the Chief Inspector for fire alarms sounding. The inspector was informed that parts had been ordered to replace smoke detectors following servicing and were due to be replaced in the coming days.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While some care plans reviewed were individualised to the residents need, some gaps and discrepancies were were observed in other assessments and care plans. Action was required to ensure that residents care needs were met. For example:

- A resident had been assessed for new equipment to support their mobility needs and the new equipment was in use. However, the residents care plan had not been updated and did not reflect the residents current care needs as assessed by an occupational therapist.
- A resident with responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had a care plan in place. However, the residents' care needs had not been reassessed and their care plan had not been updated following an incident. The care plan in place and did not reflect the residents' current support needs and also lacked detailed person-centred information to guide staff practice to effectively respond to the responsive behaviour.
- Another resident with responsive behaviours had an antecedent, behaviour, and consequence (ABC) chart in place, which captured details of incidents that had occurred to gain an understanding of responsive behaviours to aid in the development of techniques to support the resident. The resident had a care plan in place, however, this did not reflect the information in the ABC chart and had not been updated following incidents that had occurred. The information in the care plan was generic and did not effectively guide staff practice during episodes of responsive behaviour.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Since the last inspection some improvements were observed in the use of restraint in accordance with the national policy. Residents who were in tilted-back seating had all been referred to an occupational therapist (OT) for assessment to ensure they had appropriate equipment for their clinical needs. On the day of inspection this seating was not used to restrict residents movement and was not placed into a tilted position.

A risk register was maintained and staff spoken with were familiar with it and had good oversight of the restrictive practices used by residents.

Residents with restrictive measures in place had been assessed and had care plans in place to guide staff. Alternatives trialled prior to the current restraint being used were documented and written consent was sought from residents for care and interventions when required. Multi-disciplinary (MDT) input was sought to support

the assessments and decision-making process to enable the best outcomes for residents. Records were also maintained of when restraints such as bedrails were applied and checked.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had taken action to improve the provision of activities since the last inspection, and resident feedback in general was that they liked the activities provided. The vacant activity staff position had also been filled and there were some varied activities provided on the day of inspection for residents.

Improvements were also observed with residents choice over how they spent their day and when they were woken up. Residents spoken with also described having choice and freedom in the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lawson House Nursing Home OSV-0000244

Inspection ID: MON-0041391

Date of inspection: 08/05/2025

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**
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: The activity office has been changed to a Nursing Admin Office, but the function remains the same for office use only by staff. The Family overnight room has an ensuite toilet. This was constructed in 2012. The omission of the ensuite to the family room was an oversight in the floor plans and Statement of Purpose which has since been corrected in the revised floor plan. The additional room was built onto the cinema room to accommodate safe visiting during the COVID 19 pandemic. This was a temporary structure and has since been removed. An application to vary was submitted to the chief inspector. This application was in the process of being reviewed at the time of the inspection. Management will ensure that any proposed modifications to the footprint of Lawson House Nursing Home in the future will be notified beforehand to the chief inspector. Any approved changes will be reflected in the floor plans and Statement of Purpose. Estimated Time Frame for Completion: 22.08.25	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Ongoing recruitment is in place for suitably qualified staff. Call bell audits are discussed at staff handover meetings and monthly staff meetings. The Clinical Nurse Managers continue to overview and support staff in striving to answer call	

bells in a timely manner.
Audits to continue as part of continual quality improvement.

Estimated Time Frame for Completion: Ongoing

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The person in charge will resume full time working hours. The Statement of Purpose has been updated to reflect this.

Care Plans: See Compliance Plan for Regulation 5 –

Every Resident has a comprehensive person-centered care plan based on validated risk assessment tools. These care plans are reviewed at regular intervals, not exceeding 4 months. All Resident care plans will be reviewed following an event that causes a change to the individual plan of care for example when new equipment is received and following an incident.
We are in the process of updating and revising our current care plan system with new Person-Centered frameworks to ensure we satisfy the regulations by providing a person-centered care plan that belongs to the Resident, is user friendly, and easy to implement. These have been introduced for all new Residents going forward and will be assigned to all current residents.

Fire Safety Management: See Compliance Plan for Regulation 28 –

Fire Drills will be organised at suitable intervals with some drills conducted to simulate nighttime conditions. Since the inspection 3 simulations have been completed – 2 nighttime (July 2nd & 16th) and 1 daytime (July 10th).

Fire training for new staff was scheduled and completed on August 6th.

As part of our ongoing safety efforts, we plan to conduct three night time fire simulations in every quarter.

The Centre's policy for fire safety will be reviewed and updated to include clear direction for staff.

Daily Fire checks will continue to be recorded and will include checking that exit routes

are clear and free from trip hazards and debris. This will be overviewed to ensure there are no gaps in the paperwork.

Servicing and replacement of equipment by fire engineers has been completed. A new fire panel has been purchased, and we are awaiting confirmation of installation date.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Some Residents in the centre have keys to their bedroom as per their request. We always provide a key to Residents who wish to have one. We will ensure that every Residents who would like a key to their bedroom has one. In addition, Resident name and photograph is displayed by the bedroom door for all Residents who provide consent to minimise other Residents mistaking the room and entering.

In addition, Staff will continue vigilance with Residents' rooms and property by:
1. Encouraging Residents at high risk of entering rooms to attend activities of choice.
2. Responding to any concerns voiced by Residents regarding property in a proactive way.

Estimated Time Frame for Completion: 01.08.2025

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Seating: An audit of the current seating was completed. Based on the outcome an action plan is being developed and will be put in place to make these lounge areas more comfortable, attractive and user friendly based on Residents' needs. All low chairs have been removed. "Office Chairs" are available for the use of visitors in public areas and for staff when sitting with Residents.

The three lounge areas – Barrow, Nore and Suir have been repainted, new TVs installed, decorated with pictures and seating has been rearranged. All three lounges are now in use by the Residents. This plan was in place prior to the inspection.

Outdoor Areas: Gaps in the stone paving will be addressed and made safe. Weeds and debris have been removed and will be monitored by maintenance staff.

A new maintenance person has been recruited since the inspection and the Statement of Purpose has been updated to reflect this.

The cinema room in the Centre has been reverted to a prayer room and all maintenance work has been completed. This room is now in use by the Residents.

Estimated Time Frame for Completion: 15.08.2025

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Drills will be organised at suitable intervals with some drills conducted to simulate nighttime conditions. Since the inspection 3 simulations have been completed – 2 nighttime (July 2nd & 16th) and 1 daytime (July 10th).

Fire training for new staff was scheduled and completed on August 6th.

As part of our ongoing safety efforts, we plan to conduct three nighttime fire simulations in every quarter.

The Centre's policy for fire safety will be reviewed and updated to include clear direction for staff.

Daily Fire checks will continue to be recorded and will include checking that exit routes are clear and free from trip hazards and debris. This will be overviewed to ensure there are no gaps in the paperwork.

Servicing and replacement of equipment by fire engineers has been completed. A new fire panel has been purchased, and we are awaiting confirmation of installation date.

Estimated Time Frame for Completion: 15.09.2025

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:
Every Resident has a comprehensive person-centered care plan based on validated risk assessment tools. These care plans are reviewed at regular intervals, not exceeding 4

months. All Resident care plans will be reviewed following an event that causes a change to the individual plan of care for example when new equipment is received and following an incident.
We are in the process of updating and revising our current care plan system with new Person-Centered frameworks to ensure we satisfy the regulations by providing a person-centered care plan that belongs to the Resident, is user friendly, and easy to implement. These have been introduced for all new Residents going forward and will be assigned to all current residents.

Estimated Time Frame for Completion; 31.10.2025

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
Registration Regulation 7 (2)	An application under section 52 of the Act must specify the following: (a) the condition to which the application refers and whether the application is for the variation or the removal of the condition or conditions; (b) where the application is for the variation of a condition or conditions, the variation sought and the reason or reasons for the proposed variation; (c) where the application is for the removal of a condition or conditions, the reason or reasons for the proposed removal; (d) changes proposed in relation to the	Substantially Compliant	Yellow	22/08/2025

	designated centre as a consequence of the variation or removal of a condition or conditions, including: (i) structural changes to the premises that are used as a designated centre; (ii) additional staff, facilities or equipment; and (iii) changes to the management of the centre that the registered provider believes are required to carry the proposed changes into effect.			
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	01/08/2025
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	Not Compliant	Orange	30/09/2025

	residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.			
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	15/08/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	15/08/2025
Regulation 23(1)(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	05/08/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	15/09/2025

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	15/08/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	15/09/2025
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	Substantially Compliant	Yellow	31/10/2025

	that resident's family.			