Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Coastguards
Name of provider:	Health Service Executive
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	01 October 2025
Centre ID:	OSV-0002567
Fieldwork ID:	MON-0048238

About the designated centre

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

This designated centre can provide residential care and support for up to six residents with disabilities, both male and female. The centre is a large two-storey house which accommodates five residents downstairs and one resident in a self-contained apartment upstairs. The downstairs accommodation comprises a well-equipped kitchen, a dining room, a utility room, a sunroom, five bedrooms (one of which has an en-suite bathroom) and three communal bathrooms. The apartment upstairs comprises a kitchen and sitting room, a bedroom, a bathroom, a storeroom and an office. There is a garden to the front of the house with a private parking space. To the back of the house, there is a large garden with a patio area. Transport is available to residents so that they can access both community-based facilities and undertake longer trips. There is a full-time person in charge who is supported by a team of nursing staff and healthcare assistants

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 1 October 2025	10:00hrs to 17:00hrs	Eoin O'Byrne	Lead
Wednesday 1 October 2025	10:00hrs to 17:00hrs	Caroline Meehan	Support

What residents told us and what inspectors observed

An unannounced inspection was conducted by in response to both solicited and unsolicited information received. The information raised concerns in the following areas:

- staffing practices
- incident reporting and response mechanisms
- provision of healthcare supports
- governance and management arrangements.

Prior to the inspection, the provider was requested to submit assurances regarding the concerns raised in the unsolicited information. In response, the provider submitted a detailed action plan outlining proposed measures to improve the care and support provided to residents.

The concerns raised, along with the provider's submitted assurances, formed the primary lines of inquiry for this inspection. Inspectors found that aspects of the issues raised in the unsolicited information were substantiated upon review.

A total of six regulations were assessed during the inspection. Of these, two were found to be non-compliant: Regulation 6: Healthcare and Regulation 26: Risk Management Procedures

Two were found to be substantially compliant: Regulation 23: Governance and Management and Regulation 5: Individualised Assessment and Personal Plan

The inspection involved a comprehensive review of documentation and practices. Inspectors identified systemic deficiencies in the areas assessed. In particular, the systems in place to ensure that residents' needs were appropriately identified, documented, and met were found to be inadequate.

While there was evidence of initial efforts to support residents, inspectors noted a lack of sustained implementation and follow-through. This resulted in required actions not being completed, thereby impacting the quality and consistency of care provided.

During the inspection, inspectors engaged with two residents, four staff members, a person in charge from another of the provider's services, an advanced nurse practitioner and two members of the provider's senior management team.

At the commencement of the inspection, all residents were engaged in activities outside of the designated centre, including attendance at day service programmes and health-related classes. Inspectors met with one resident who spoke positively

about the health class they had attended. The resident appeared comfortable in their interactions with staff and relaxed in their home environment.

Additionally, an inspector contacted three family members of residents currently residing in the service. One family member was available to speak and provided positive feedback regarding the service. They highlighted the range of social activities available to their loved one and reported effective communication with the staff team. The family member expressed confidence in the care being provided, stating that they felt their loved one was well supported and cared for.

While a family member gave positive feedback regarding the service the overall findings of the inspection indicate a need for targeted and sustained improvements in the areas of governance, care planning, healthcare provision, and risk management. These improvements are necessary to ensure compliance with regulatory requirements and to safeguard the wellbeing of residents.

The next two sections of the report outline 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 residents lives.

Capacity and capability

A review of the leadership and management arrangements within the designated centre was undertaken. Following the receipt of both solicited and unsolicited information a decision was made that the inspection would focus on the provider's response to the evolving needs of residents and the adequacy of care and support provided.

The inspection identified that the centre's governance and oversight arrangements had not been effective in ensuring the timely identification and resolution of service delivery issues. Specifically, systems intended to monitor and update residents' information were found to be deficient, resulting in records that did not accurately reflect current needs.

It was noted that for a period, the provider's governance structures failed to detect the need for improvements. The impact of these failures is addressed in further detail in subsequent sections of this report.

In recent weeks, the provider has taken steps to address the identified concerns. The provider has held four serious incident management team (SIMT) meetings. Outcomes from these meetings included:

- increased clinical input from an advanced nurse practitioner
- engagement of an external clinical nurse manager to review and update residents' records

- development of a targeted action plan to address deficiencies identified during SIMT reviews and to ensure timely implementation of assurances submitted by the provider
- a decision to commission a systems analysis review of the service provided to residents.

While these actions are acknowledged as positive and proactive, the inspection findings confirm that the issues should have been identified and addressed through routine governance and oversight mechanisms.

Staffing levels, skill mix, and training provision were reviewed as part of the inspection process. These areas were found to be compliant with the relevant regulatory requirements.

The provider has demonstrated a willingness to respond to concerns and implement corrective actions. However, the inspection has highlighted significant failings in governance and oversight that must be addressed to ensure the ongoing safety and well-being of residents. The provider is required to ensure that robust systems are in place to monitor service provision effectively and to respond promptly to emerging risks.

Regulation 15: Staffing

The inspector reviewed the provider's staffing arrangements and found them to be appropriate to meet the assessed needs of residents. Planned and actual staff rosters were available for review. Rosters examined for the periods 1 to 31 August and 15 to 30 September 2025 demonstrated that safe staffing levels were consistently maintained.

The service was nurse-led, with a registered nurse on duty during both day and night shifts. Residents were supported by a consistent staff team, which included a significant number of regular agency personnel. This consistency contributed positively to continuity of care.

Throughout the inspection, inspectors engaged with staff members who demonstrated sound knowledge in key areas such as safeguarding, pain identification, and appropriate care responses. However, inconsistencies were noted in staff members' understanding of procedures to follow in the event of a suspected or witnessed fall. This issue will be addressed in greater detail under Regulation 26: Risk Management.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector verified that all staff members had access to, and had completed, the required training modules. A review of training records confirmed that the provider and the person in charge had taken appropriate action to address a training-related non-compliance identified during the March 2025 inspection. Specifically, the action concerning dementia-focused training had been satisfactorily resolved, with all staff having completed relevant training in this area.

In addition, the inspector noted that the staff team had received training in the following mandatory and supplementary areas:

- Safeguarding of Vulnerable Persons
- Children First
- Fire Safety
- Managing Behaviours That Challenge
- Manual Handling
- Infection Prevention and Control Measures
- Basic Life Support
- Medication Management
- Feeding, Eating, Drinking and Swallowing
- Dementia Care
- Epilepsy Awareness.

The training records reviewed were up to date and demonstrated compliance with regulatory requirements under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors evaluated the governance and management arrangements in place to determine their effectiveness in overseeing resident care and support. The inspection identified that significant improvements were required, particularly in relation to oversight of residents' health and care needs.

Gaps in documentation were noted, and required follow-up actions had not been completed. This failure in oversight directly impacted the quality of care and support provided to certain individuals. These findings will be further detailed under:

- Regulation 5: Individualised Assessment and Personal Plan
- Regulation 6: Healthcare.

Concerns were also raised regarding risk control and management practices. While risk assessments had been developed across several areas, there was limited procedural guidance available to staff following a witnessed or unwitnessed fall

involving a resident. This issue will be discussed in more detail under: Regulation 26: Risk Management Procedures

A review of audits conducted between May and September 2025 showed that the service had undertaken reviews in the following areas:

- adverse incidents
- financial management (including enhanced financial audits
- complaints
- fire safety.

However, the documentation reviewed did not demonstrate effective auditing or review of records specifically related to resident care and support during the months of May, June, July, and August.

Following an incident in the service, the provider commissioned a comprehensive review of all resident information in September, conducted by an external party. While the completion of this review was a positive step, it raises concerns that effective auditing of resident care and support information had not occurred for an extended period, resulting in records that did not accurately reflect the evolving needs of some residents.

As noted in an earlier section of the report the provider was in the process of addressing these issues, however, inspectors were concerned that the governance and management systems in place at that time were not effective in picking up these issues which had the potential to put residents at risk.

Judgment: Substantially compliant

Quality and safety

The inspection identified failings in the care and support provided to some residents. While aspects of care were maintained to a good standard for certain individuals, inspectors found inconsistencies in how residents' needs were assessed and met across the service.

Specifically, gaps were noted in the staff team's responsiveness to the changing needs of residents. In several instances, staff lacked access to appropriate guidance and protocols necessary to deliver consistent and person-centred care. This was compounded by deficiencies in the provider's and management team's oversight, which failed to ensure that clear and effective support frameworks were in place.

Concerns were also identified regarding:

- the adequacy of assessments of residents' needs
- the provider's response to residents' changing health conditions

- the identification and management of risk by both the provider and the person in charge.

These findings indicate that the systems in place were not sufficiently robust to ensure safe, effective, and responsive care for all residents.

Regulation 26: Risk management procedures

Significant improvement was required in the management of risks and incidents in the centre, in terms of providing adequate monitoring at the time of incidents, appropriate and timely follow up reviews and to ensure appropriate measures were in place to ensure the safety of residents.

The inspectors reviewed records of incidents which occurred between June, July, August and September 2025. In some instances appropriate care and follow up actions had been taken to ensure the safety of residents. However, the management of unwitnessed falls, or in one instance, healthcare monitoring following a resident hitting their forehead, was not sufficiently comprehensive. There were incidents where neurological observations had not been completed for a resident, after banging their head, and falling a number of times without anyone witnessing the fall. Adequate measures had not been taken at the time to provide assurances on the wellbeing of the resident.

In addition, where a resident required assistance from the floor, there was no guidance in place to ensure manual handling techniques were safe for this procedure. While the resident has been assessed by an occupational therapist, in January 2025 for transfers using a hoist, the emerging need for updated review and manual handling guidance for floor transfer had not been referred to the occupational therapist. Therefore there was no guidance in place to safely transfer the resident from the floor following a fall, or loss of power in their legs. The inspectors noted that on one occasion three staff and on another occasion two staff had manually supported the resident from the floor.

Falls risk assessments had been completed for the resident, and it was identified that they were at high risk of falls. Reviews of the falls risk assessment had been completed in April and June 2025, and a further falls risk assessment on the 30 June 2025, whereby it was documented the resident had experienced five falls, and one possible fall or behavioural incident where the resident was found in their room on their knees, with the cause unknown.

The inspectors spoke to a three staff about the measures to ensure the resident's safety, and staff described that the resident was supervised by one staff at all times. The risk assessment outlined staff were to liaise with the general practitioner (GP) or mental health professionals when a decline in the resident’s mobility was observed, However, as mentioned there had been no review of the resident's

mobility needs by a physiotherapist, and no in person review by the GP at the time of incidents to asses for potential injuries.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Appropriate multidisciplinary assessments had not been completed in response to the changing needs and emerging healthcare risks for a resident, which meant that appropriate arrangements were not in place to meet the needs of the resident. This in turn meant that practices in the centre related to the care and support for the resident were not safe and appropriate.

The inspectors reviewed two residents files, and while appropriate assessment and support plans were in place for some residents, up-to-date multidisciplinary assessments were not in place for one resident, including physiotherapist, speech and language therapist assessments and diagnostic tests. This in turn meant that plans and care provision were not informed by the most relevant information, given the resident's changing presentation. This is further discussed in regulation 6.

There were plans of care in place for residents, however, for one resident plans of care did not adequately reflect their changing needs, as well as the potential risks to their wellbeing.

Judgment: Substantially compliant

Regulation 6: Health care

Appropriate healthcare was not provided to a resident in line with their changing needs.

As mentioned, appropriate healthcare assessments were not completed for a resident, in terms of their mobility, safety, and to identify healthcare risks. This included a physiotherapy assessment, an updated feeding, eating, drinking and swallowing assessment, blood tests, and ensuring that reasonable measures had been pursued to complete a bone density scan.

For example, a GP had made a referral to a physiotherapist in December 2024, on the recommendation of a hospital consultant. This was due to the resident's changing needs and reduced mobility. A physiotherapist had made contact with the centre within approximately six weeks; however, the physiotherapist was informed that the resident's mobility had returned to baseline, and noted no physiotherapy was required at the time. In the interim, the resident continued to experience

episodes affecting their mobility, however, no further contact was made with a physiotherapist for review.

A holistic approach to care was not in place, to ensure the known healthcare issues, and possible healthcare risks for a resident were being supported appropriately. This included, for example, a known health care need of vitamin deficiency, which may alert to possible risks related to bone health. In this instance appropriate blood screening had not been completed, as well as pursuing alternative tests to a bone density scan. This in turn would inform practice around manual handling, and the management of falls. This is further discussed in regulation 26.

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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Coastguards OSV-0002567

Inspection ID: MON-0048238

Date of inspection: 01/10/2025

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The governance and management oversight systems have been reviewed to ensure proactive action to the needs of residents.
In relation to risk control management practices, the falls prevention policy has been reviewed and now includes a post falls protocol. This protocol is a guide for staff to follow in relation to supporting residents after a witnessed or unwitnessed fall.

This protocol has been rolled out within the Designated Centre and will be discussed at team meetings.

Manual handling refresher training for supporting the falling and fallen person will be carried out on 09/12/2025 for all staff within the Designated Centre.

Falls training programme has been sourced through the local CNME department for all staff within the Designated Centre. Training dates have been scheduled for Quarter 1 2026.

The Person in Charge will develop and implement a Quality Assurance tracker for the Designated Centre. This tracker will record all the actions arising from audits that are being carried out and timeframes for which actions are to be completed. The progress on the implementation of any corrective action will be monitored by the PPIM to support the PIC.

The DON/ADON will have access to the Quality Assurance tracker on the shared drive for the overarching monitoring of care delivery within the Designated Centre. The DON/ADON will review the Quality Assurance tracker with the Person in Charge at their weekly governance reviews on site and via Microsoft teams as appropriate.
Actions from the audits and their status for completion will be discussed with the keyworkers and staff team at the house team meetings to ensure that actions are being

completed within the allocated timeframes.

Each resident within the Designated Centre has two keyworkers, one of whom is a registered nurse and they are responsible to ensure all residents information within the healthcare documentation is accurate and is reviewed as residents needs change or within recommended timelines as per the Service policy on Person Centred Planning or in line with best practice.

Each resident has an annual review carried out with their family representative, assisted decision-making representative, keyworkers, relevant allied healthcare professionals, PIC and ADON as required. All aspects of care delivery are reviewed during this meeting. The annual review is recorded and retained as part of the residents personalise care & support plan.

All registered nurses will complete the HSEland training on the MEG auditing system to support the Person In Charge in auditing healthcare documentation.

All registered nurses have completed training in the Fundamentals of Nursing Documentations, led out by the local CNME.

The Registered Advance Nurse Practitioner in Chronic Illness Management is available Monday to Friday to support residents care, particularly in relation to their medical needs and since the inspection has completed reviews of all residents to support the staff team in managing known healthcare issues and responding to any new or emerging healthcare concerns.
Registered Advance Nurse Practitioner in Chronic Illness Management has a referral pathway for residents within the service. This standard operating procedure has been implemented within the services. All staff have signed to confirm they have read and understood the Registered Advanced Nurse Practitioner Role Definition and Professional Standards Guideline.

Registered Advance Nurse Practitioner in Chronic Illness Management is implementing a 'Stop and Watch' clinical assessment tool, which will support staff when assessing a resident's clinical presentation. Training has been rolled out within the Designated centre 13 staff have completed this training to date, a further training date has been arranged for the 26th November in the designated centre for the remaining staff team.

This assessment tool will also support assessing a resident who may decline to have their neurological or clinical observations to be carried out.

The Registered Advance Nurse Practitioner in Chronic Illness Management will carry out a follow up clinical audit in the designated centre in January 2026.

There is a Manager on call governance arrangement in place for out of hours where staff on duty in the centre can report any incidents or concerns they may have during out of hours. The Manager on call report template has been updated to include a follow up section where DON/ADON can record any follow up actions discussed with the PIC/Staff Nurse within the centre.

The PIC will ensure additional professional development training undertaken is implemented in practice through daily observations and at staff appraisal meetings.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The falls prevention policy has been reviewed and now includes a post falls protocol. This protocol is a guide for staff to follow in relation to supporting residents after a witnessed or unwitnessed fall. This protocol includes all clinical assessments or medical interventions that are required for the resident post a witnessed or unwitnessed fall to include review by their GP and referral to either physiotherapist or OT for review.

All staff within the Designated Centre have read and signed the post falls protocol, this protocol is also on display within the Designated Centre and will be discussed at the next team meeting scheduled for the 19/11/2025.
Residents who are assessed as being at a high risk of falls have the post falls protocol included as an outcome measure as part of their risk assessments.

Each resident's manual handling assessment has been reviewed to ensure that they include all the supports a resident may require for transfers.

Manual handling refresher training for supporting the falling and fallen person will be carried out on 09/12/2025 for all staff within the Designated Centre.

Falls training programme has been sourced through the local CNME department for all staff within the Designated Centre. Training dates yet to be scheduled.

Incident Management training has been carried out by service risk advisor, included in this training was incident reporting, incidents reviews and analysis. 3 staff from the Centre have completed this training to date, a further training date has been scheduled for 18-11-2025 additional dates will be scheduled for any remaining staff in the designated centre.

Registered Advance Nurse Practitioner in Chronic Illness Management is implementing a 'Stop and Watch' clinical assessment tool, which will support staff when assessing a resident's clinical presentation.

This assessment tool will also support a resident who may decline to have their neurological or clinical observations to be carried out.
Training has been rolled out within the Designated centre, 13 staff to date have completed training. The Registered Advance Nurse Practitioner in Chronic Illness Management will carry out a follow up clinical audit in the designated centre in January

2026.

Any necessary follow up actions from the clinical audit will be followed up with the staff team through team meetings & staff supervisions. The Person in Charge and Registered Advance Nurse Practitioner will continue to monitor the implementation of the assessment tool monthly.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Since the inspection the healthcare assessments for each resident have been reviewed. Each resident within the Designated Centre has two keyworkers, one of whom is a registered nurse and they are responsible to ensure all residents information within the healthcare documentation is accurate and is reviewed as residents needs change or within recommended timelines as per the service policy on Person Centred Planning or in line with best practice.

Referrals to allied health professionals are made through the local primary care department. This is now further reinforced through the introduction of the revised falls protocol. Allied health professionals assessments and reports contain all relevant information that is required to guide staff practises.

The registered nurse develops individual care plans based on the recommendations from the allied health professionals. The Person in Charge will monitor the healthcare documentation through the services audit process.

Any actions arising through the auditing process will be included in Designated Centre's Quality Assurance tracker.

The DON/ADON will review the Quality Assurance tracker with the Person in Charge at their weekly governance meetings.

Actions from the audits and their status for completion will be discussed with the keyworker and staff team at the house team meetings and staff supervisions to ensure that actions are being completed within the allocated timeframes.

Registered Advance Nurse Practitioner in Chronic diseases is implementing a 'Stop and Watch' clinical assessment tool across the service. This will support staff in the designated centre when assessing a resident's clinical presentation.

This assessment tool will also support a resident who may decline to have their neurological or clinical observations to be carried out.

Training has been rolled out within the Designated centre, 13 staff to date have completed training, and further training has been scheduled to capture the remaining staff.

Each resident has an annual review carried out with their family representative, assisted decision-making representative, keyworkers, relevant allied healthcare professionals, PIC and ADON as required. All aspects of care delivery are reviewed during this meeting. The annual review is recorded and retained as part of the residents' personal care & support plan.

The registered nurses carry out health assessments for residents on a six monthly basis, or more frequently if a residents needs have changed, or healthcare risks have been identified.

Based on the assessment health needs of the individual resident or recommendation from GP/Allied health professional, the frequency for monitoring clinical observations, weight, BMI etc. will be included in the resident plans of care.

The Person in Charge and Registered Advance Nurse Practitioner will monitor the implementation of the assessment tool; any necessary follow up with the staff team will be carried through team meetings & staff supervisions.

The Personal Care & Support Plan audit tool will be reviewed and updated to ensure that all aspects of the individuals' needs assessment and care delivery are captured.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Since the inspection the healthcare assessments for each resident have been reviewed and each resident has been medically reviewed by their GP.

The Centre has access to a team of allied health care professionals via the adult community ID team and the Primary care team to include Physiotherapist, SLT, dietician and OT. The registered nurses/key workers have developed individual care plans based on the recommendations from the allied health professionals. These have been reviewed since the inspection to ensure up to date recommendations and input from the allied health team are appropriate to the current care needs of residents.

Routine monitoring of weight, blood pressure and other clinical observations are completed weekly to monitor the health needs of residents and referral for investigation completed based on these reviews.
Blood screening is carried out on an annual basis for all residents or more frequently

based on the GP request or on the medical conditions, which requires monitoring. The registered nurse liaises with the GP or relevant allied health professionals to review findings of this test/screening.

Residents are encouraged to take part in all National screening programmes for bowel checks, breast checks, cervical & prostate checks.

Where difficulty to accessing healthcare screening is identified, the Person in Charge will liaise with the residents GP, Allied health professionals, Registered Advance Nurse Practitioner & DON/ADON to discuss an alternative plan of care to best support the individual resident.

There is a Registered Advance Nurse Practitioner in Chronic Illness Management is available to the Service to support residents care particularly in relation to their medical needs and staff training and upskilling.

Registered Advance Nurse Practitioner in Chronic Illness Management has a referral pathway for residents within the service. This standard operating procedure has being implemented within the services.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/01/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/03/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive	Substantially Compliant	Yellow	30/01/2026

	assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/01/2026