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:	Beech Lodge Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Kilmallock Road, Bruree, Limerick
Type of inspection:	Unannounced
Date of inspection:	28 May 2025
Centre ID:	OSV-0000408
Fieldwork ID:	MON-0045689

About the designated centre

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

Situated in the village of Bruree, County Limerick, Beech Lodge Care Facility offers long term care, rehabilitative care, respite care and convalescent care for older adults. The age range catered from is 18 to 65+. Our care facility is a 66-bed facility which is made up of 48 single en-suite bedrooms and nine double en-suite bedrooms. There is 24-hour nursing care available from a team of highly trained staff. Our mission is to promote the dignity and independence of residents. The designated centre provides short & long-term care, respite/convalescence and palliative care and care for residents' with dementia. Here at Beech Lodge an individual programme of activities is tailored to each individual resident. Referrals for admission may come from acute or long-term facilities, community services or privately. Private admissions are arranged following a pre-admission assessment of needs including medical background, dietary requirements etc. We aim to provide the best care possible and use a variety of care assessment tools to help us to do this. We also involve both the resident and their representative in this process. We provide a GP and physiotherapy service to all residents. We aim to make dining a social experience. Individual dietary requirements are incorporated into the menu planning process. Catering personnel are trained in the appropriate skills and are supported by the dietitian and the speech and language therapist (SALT). The facility has its own mini bus for the use of residents. There is a monthly residents' meeting to discuss issues ranging from activities, improvements in daily life, the environment and other issues. Activities include: newspapers, exercises, brain games, music, mass, art, baking, hairdresser, bingo, sensory therapy, and much more. We are interested in feedback to ensure that our service is continually reviewed in line with best practice. Visitors are welcome and local community events are accessible.

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
Wednesday 28 May 2025	19:00hrs to 21:50hrs	Una Fitzgerald	Lead
Thursday 29 May 2025	10:00hrs to 18:30hrs	Una Fitzgerald	Lead
Wednesday 28 May 2025	19:00hrs to 21:50hrs	Rachel Seoighthe	Support
Thursday 29 May 2025	10:00hrs to 18:30hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

This unannounced inspection took place over one evening and one day. Inspectors spoke with many of the residents living in Beech Lodge Care Facility. Overall, the feedback from residents was mixed. Some residents spoke very positively about the care they received and told inspectors they loved their life in the centre. In contrast, other residents told inspectors that they had to wait for long periods of time to have their care needs attended to, and that they felt that this was due to inadequate staffing levels. Some residents also expressed concern at the high level of staff changes and the challenge this posed for them, with new staff not knowing their individual care needs.

On the first evening of the inspection, there was a registered nurse on duty in charge of the centre. A senior nurse was informed that an inspection was in progress and attended the centre, along with members of the management team.

Beech Lodge Care Facility was a purpose built centre, registered to provide long term and respite care to a maximum of 66 residents.

At the entrance to the centre, there was a reception area which contained offices and a nurses station. Notice boards with information leaflets on how to make a complaint and how to access advocacy services were located at the reception area. Inspectors observed that two different versions of the centre's complaints procedure were displayed at the reception area, which could cause confusion for residents or visitors who may wish to raise a complaint or concern.

There was a variety of communal spaces for residents' use, including a large dining room, a visitors' room and two large communal sitting rooms. The centre was divided into two main areas. The upper area, known locally as the main unit, and the back part of the centre known as the Daffodil unit.

On the first evening of the inspection, 62 residents were accommodated in the centre. When the inspectors arrived to the centre, they observed that there was a small number of residents up and about. The majority of these residents were sitting in a large day room, opposite the reception area, which was being supervised by a member of staff. A small number of residents were observed mobilising independently around circulating corridors, and inspectors were informed that some residents were in their bedrooms, watching television. Inspectors spent time chatting with, and observing residents in the various areas of the centre.

Some residents spoken with told the inspectors that they were not satisfied with the length of time it took to have their call bells answered. By way of example, shortly after 9pm a resident told the inspectors that they had requested to go to their bed at 8pm and were still waiting for assistance.

The Daffodil unit accommodated residents with a diagnosis of dementia. Several of

the residents had been assessed as being at high risk of falls and were also known to display varying levels of responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). On the first evening of inspection, the inspectors observed that there was no access to the dining room in this area, as it was locked. Staff informed inspectors that this area was locked so that the residents could be supervised in the large communal area.

On the morning of the second day of inspection, inspectors completed a walk around of the designated centre, giving an opportunity to observe the meet with other residents and staff. Overall, the premises were observed to be clean. A small number of residents told inspectors that their bedrooms were cold and that they had reported this concern to the staff.

Residents expressed concern at the length of time it took to have their call bells answered and have their care request attended to. Residents told inspectors that staff answered the bells, with a response that they would endeavor to return as soon as possible. Inspectors heard a resident calling out for help. On speaking with the resident it was observed that the resident did not have their call bell within reach and so could not call for assistance. Inspectors observed multiple examples on the second day of inspection whereby residents did not have their call bells within reach.

Visitors were observed being welcomed into the centre throughout the inspection. Residents met with their friends and loved ones in their bedrooms or communal rooms. In the main, visitors spoken with provided positive feedback on the care their relatives received.

The next two sections of this report present the findings of this inspection in relation to the governance and management of the centre and how these arrangements impact on the quality and safety of the service provided to residents.

Capacity and capability

This unannounced inspection was carried out by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- review monitoring notifications submitted by the provider to the Chief Inspector in relation to the safeguarding and protection of residents, and the management of residents that were at risk of absconsion.
- review unsolicited information received by the Chief Inspector, pertaining to staffing and the quality of direct care provided to the residents living in the centre.

Overall, the findings of this inspection were that the management systems in place

to monitor and oversee the service were not robust and did not provide adequate assurance that a safe and quality service was consistently provided.

Beech Lodge Care Facility Limited is the registered provider of the centre. There was no person in charge of the centre at the time of this inspection. The position had been vacant since 18 April 2025. The registered provider had failed to ensure that there was a person in charge of the centre who met the requirements of Regulation 14; Person in charge. An assistant director of nursing worked full-time in the designated centre and was the nurse in charge of the centre. They were supported by a senior staff nurse who worked in a supervisory position. The management structure was supported by a person representing the registered provider and a newly appointed operations manager. Due to the risk associated with the absence of a suitably qualified and experience person in charge, the Chief Inspector had requested written assurances from the registered provider that there would be a person appointed to the position of the person in charge, who met the requirements of the regulations. The provider failed to respond to the Chief Inspector within the requested time frame.

Risk management systems were underpinned by the centre's risk management policy. The policy detailed the systems in place to identify, record and manage risks that may impact on the safety and welfare of the residents. As part of the risk management systems, a risk register was maintained to record and categorise risks according to their level and priority of risk. The inspectors found that the absence of a person in charge was not identified by the provider as a risk and therefore a risk assessment and mitigating measures were not recorded.

Record management systems consisted of both an electronic and a paper-based system. A sample of staff personnel files were reviewed and did not contain all the information required by Schedule 2 of the regulations. This included a vetting disclosure for each member of staff in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. In addition, some records, required to be maintained in respect of Schedule 3 and 4 of the regulations, were not appropriately maintained. This included records pertaining to the nursing care provided to residents, and records of adverse incidents involving residents. For example, not all recorded incidents contained the results of an investigation of the incident.

A review of staffing found that the centre had a high level of staff turnover which was a risk to the continuity of a high standard of care. The team providing direct care to residents consisted of registered nurses, and a team of health care assistants. There were sufficient numbers of housekeeping, catering and maintenance staff in place. Staffing numbers and skill mix on the day of inspection were appropriate to meet the individual and collective need of the residents, with the exception of the evening time. This detail is outlined under Regulation 15: Staffing.

Although the provider had made arrangements to facilitate training for staff, records viewed by inspectors on the day of the inspection indicated that some staff had not completed appropriate training. For example, not all staff had completed mandatory

safeguarding training. Furthermore, the provider had not assessed the effectiveness of the training delivered. Some staff spoken with did not demonstrated appropriate awareness in relation to recognising and responding to incidents of abuse.

A centre-specific complaints policy detailed the procedure in relation to making a complaint and set out the time-line for complaints to be responded to. However, the management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely manner and resulted in inconsistent recording of complaints. For example, multiple complaints were not appropriately documented or managed within the complaints register, or in line with the centre's own complaints management policy.

Regulation 14: Persons in charge

At the time of inspection there was no person in charge of the centre who met the requirements of the regulations.

Judgment: Not compliant

Regulation 15: Staffing

The number and skill mix of staff was not adequate to meet the needs of the residents taking into account the size and layout of the designated centre. This was evidenced as follows:

- the staffing levels did not ensure that staff could appropriately supervise residents in communal areas in the Daffodil unit in the evening time, while also assisting residents with and providing additional supervision and support to residents with enhanced supervision needs.
- residents were observed waiting extended periods of time for assistance.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training was not adequate to protect and promote the care and welfare of all residents. This was evidenced by;

- Incomplete staff training records. For example; there were ten staff that had

not attended their annual fire training. Some staff demonstrated poor awareness on what action to take in the event of the sounding of the fire alarm.
- There were nine staff that did not have up-to-date training on safeguarding and safety. Some staff demonstrated poor awareness in relation to regcognising and responding to safeguarding incidents.
- There were 16 staff who did not have training in the management of responsive behaviours. At the time of inspection, there were multiple residents living in the centre with a diagnosis of advanced dementia that were assessed as at risk of presenting with responsive behaviours.

Staff were not appropriately supervised. This was evidenced by inadequate supervision of staff to ensure;

- residents clinical documentation, including the assessment of residents needs and care planning, to ensure they were accurate and up-to-date.
- communication of key clinical information to staff to ensure care was delivered in line with the residents' assessed needs and care plans.

Judgment: Not compliant

Regulation 21: Records

Records were not consistently maintained as required by Schedule 2 and 3 of the regulations. For example:

- Multiple staff had commenced working in the centre prior to the receipt of valid Garda vetting.
- Multiple staff personnel files did not contain evidence of staff members' qualifications, and did not include the required number of written references from previous employers.
- Records underpinning pension agent arrangements were not available for two residents living in the designated centre.
- The preadmission assessment records for three residents were incomplete and unsigned.
- Staff rosters were not maintained in line with the requirements of Schedule 4(9), and were not reflective of the actual roster worked by staff. For example; rosters did not reflect the hours worked by the management team.
- The records of complaints logged contained insufficient detail to ensure that they could be managed in line with centres own complaints management policy.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place to monitor the quality of the service did not fully ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- The system in place monitoring nurse documentation and recording of resident current healthcare status was inadequate. A review of the clinical audits found that the system did not identify where care plans were incomplete and therefore did not contain the information required for quality improvement.
- ineffective oversight of the complaints management system to ensure the quality of care of residents was monitored, reviewed and improved on an ongoing basis. This impacted on opportunities for learning and improving the service. Complaints logged had no detail of any action taken and were closed out with no investigation or satisfaction of the complainant recorded.
- The system in place to ensure that all staff files contained the documentation required by Schedule 2 of the regulations was not effective. Staff files reviewed were incomplete.
- The risk management systems were not fully effective. For example, following two incidents of residents with high supervision needs leaving the centre unaccompanied, the risk register had not been updated to detail the controls and action required to mitigate the risks.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors found that the management of complaints was not in line with the requirements of the regulations.

A review of the complaints log in the centre found that complaints were not consistently managed in line with the centre's own complaints policy. Complaints in relation to the quality of care, the answering of call bells and the temperature of the bedrooms, that had been brought to the attention of the management team, were not appropriately documented or managed within the centre's complaints register. Consequently, there was no record of how these issues were acknowledged, investigated or resolved to the satisfaction of the complainant.

Judgment: Not compliant

Quality and safety

Residents living in the centre were generally satisfied with the quality of the service they received. Inspectors observed staff engaging with residents in a kind and gentle manner. This inspection found that the preassessment process, care planning and protection, did not meet the requirements of the regulations.

Pre-admission assessments were undertaken by the management team to ensure that the centre could provide appropriate care and services to a person being admitted to the centre. However, inspectors noted that some pre-admission assessments were incomplete and unsigned, and did not always clearly identify the residents care needs. For example, records relating to behavioural support needs were not completed for a resident who displayed responsive behaviours, and required increased supervision following their admission.

A review of a sample of resident records showed that nursing staff used validated tools to carry out assessments of residents' needs upon admission to the centre. These assessments included the risk of falls, malnutrition, assessment of cognition, and dependency levels. Overall, while some care plan records reviewed were detailed and person-centred, inspectors found that the standard of care planning was not consistent, and a number of care plans did not include sufficient up-to-date information in relation to residents' current needs. As a result, these care plans did not provide staff with adequate guidance and direction to provide safe and appropriate care for residents. This detail is outlined under Regulation 5: Individual assessment and care plan.

The inspectors found that the provider had failed to ensure that there were appropriate systems in place to support a resident that was to be discharged from the centre. The Chief Inspector had received unsolicited information in relation to the discharge of a resident from the centre. Records reviewed found no evidence of discussion to ensure that a planned discharge with agreed steps were in place to support the resident and their family and therefore this information was substantiated.

Inspectors found that the registered provider did not take all reasonable measures to safeguard residents from abuse. The provider supported a number of residents to manage their pension. However, the provider had not taken the required action to ensure that the management of all residents finances was in line with best practice guidelines. Inspectors reviewed residents' financial records and bank account statements and found that, although there was a separate bank account in place for receipt of residents' monies from the department of social protection, a number of weekly payments from the department of social protection for a resident were received into the operating bank account of the registered provider. Although records demonstrated that the provider had identified the error and taken some action to address this issue, this had not been corrected at the time of inspection.

Residents had access to internet, television, radio, newspapers and books. Religious services were available. A programme of activities was available to residents. There was an independent advocacy service available and details regarding this service

were advertised on the resident information board, displayed in the reception area of the centre. Residents' meetings were convened for residents to facilitate an opportunity to express their concerns or wishes.

There were no visiting restrictions in place and there were suitable rooms for residents to have visitors in private.

Regulation 11: Visits

The inspectors found that the registered provider had ensured visiting arrangements were in place for residents to meet with their visitors, as they wished.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The registered provider had failed to ensure that a resident who was due to be discharged from the centre had been done in line with the requirements of the regulations. For example, the provider had failed to discuss and agree the plan for discharge.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of residents' assessments and care plans reviewed by inspectors found that they were not in line with the requirements of the regulations. For example, care plans were not consistently developed, based on an assessment of need, within 48 hours of the residents admission to the centre, as evidenced by:

- A resident who was assessed as requiring high levels of supervision did not have a plan of care in place to direct staff regarding the interventions required to ensure the residents safety needs were met.

A number of care plans had not been reviewed following a change in a resident's health status or assessed need as required. This was evidenced by:

- A care plan, for a resident whose medical needs had changed, was not reviewed following the residents return from hospital. This posed a risk that changes to the residents treatment plan would not be communicated to all staff, so that the resident could be adequately supported.

- Two residents social care plans were not updated in a timely manner to reflect the care interventions required to support their needs. This did not ensure the care plan contained the the interventions required to ensure the residents social needs were met.
- The care plan for two residents who demonstrated responsive behaviours, did not contain up-to-date information regarding the arrangements in place to support and supervise the residents.
- two residents who were assessed as being at high risk of developing pressure related wounds did not have a plan of care in place until up to six days after the initial assessment.

Judgment: Not compliant

Regulation 8: Protection

The registered provider did not take all reasonable measures to protect residents from abuse. For example;

- Residents, for whom the provider acted as a pension agent, were not full protected from financial abuse. Records reviewed evidenced that a number of weekly payments from the department of social protection for one resident was deposited into the operating bank account of the registered provider. The registered provider failed to ensure that these monies were received into an account which had been set up for this purpose, separate and distinct from the operating bank account of the designated centre**.** Although records demonstrated that the provider had taken some action to address this issue this had not been corrected at the time of inspection.
- Inspectors found that several staff had not been appropriately vetted prior to commencing their respective roles in the centre.
- Records showed that nine staff had not completed training on safeguarding vulnerable adults, and some staff demonstrated a poor understanding in relation to safeguarding processes.
- Inspectors found that a potential safeguard incident was not management in line with the centre policy and procedures. For example, a preliminary screening investigation was not carried out in response to a potential financial safeguarding concern.

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	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Beech Lodge Care Facility OSV-0000408

Inspection ID: MON-0045689

Date of inspection: 29/05/2025

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**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: From the beginning of August there will be a suitable qualified PIC in place.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A staffing review was conducted and staffing levels have been adjusted to align with residents' assessed needs and dependency levels. An additional staff member has been allocated to ensure consistent supervision in communal areas and enhanced support for residents with increased supervision needs. Supervision responsibilities have been clearly outlined during handovers and in daily allocation sheets to ensure accountability and coverage at all times. Ongoing monitoring of resident needs and staffing effectiveness is in place through regular audits and feedback from residents and staff. Call bell response times are now being monitored through regular audits and logged for review by management. Spot checks and observational audits are carried out during peak times to assess response efficiency and ensure timely assistance. Staffing allocations have been reviewed and adjusted to ensure adequate coverage during high-demand periods.	

Daily handovers include emphasis on timely resident assistance and early identification of residents requiring additional support.
Resident feedback is actively sought through regular check-ins and satisfaction surveys to identify any delays in care provision.
Findings are discussed at governance meetings, and actions are taken promptly where required.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A comprehensive fire safety training session was conducted on 10th July 2025. Attendance was recorded, and all staff training records have been updated accordingly. A fire safety refresher module has now been incorporated into both the induction programme and ongoing mandatory training schedules. In addition, regular fire drills and simulated evacuation exercises are being carried out to reinforce staff response and overall fire safety awareness.

Safeguarding Training
All staff members successfully completed their safeguarding training on 15th July 2025, ensuring full compliance with mandatory training requirements. The training covered: Recognition of different forms of abuse, Reporting procedures, staff responsibilities under national safeguarding policies Staff training records have been updated. Ongoing safeguarding awareness is supported through regular supervision, team meetings, and case-based discussions.
Responsive Behaviour Training
All relevant staff completed responsive behaviour training on 15th July 2025, meeting mandatory training standards. The training focused on: De-escalation techniques, person-centred approaches, identification of triggers and early interventions and management strategies for residents with advanced dementia. Training records have been updated to reflect completion.

Monthly audits of mandatory training compliance have been implemented to ensure all staff remain up-to-date going forward.

Ongoing audits and training for nursing staff have been implemented. This was commenced on 28th May 2025, to ensure continuous improvement and compliance in documentation standards.
A structured handover process has been reinforced at shift changes to ensure consistent communication of residents' clinical needs.

Daily safety huddles have been introduced to highlight any changes in residents' conditions or care plans.

All relevant staff have received refresher training on documentation, communication protocols, and the use of electronic care planning systems.

A communication audit tool has been implemented to monitor effectiveness and ensure compliance.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
An audit of all staff files will be completed by management.

No staff will commence employment without confirmed Garda vetting in line with the regulations.

Recruitment procedures will be updated to require full documentation pre-employment. All new staff files must be signed off by the PIC before start.

All assessments will be reviewed by the COO going forward to ensure full completion and no documentation gaps.

A new electronic roster system with weekly management reviews is now in place to ensure accuracy and compliance.

The implementation of staff training has commenced to ensure full documentation and adherence to the centre's complaints policy.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Clinical audit processes will be enhanced to specifically identify incomplete care plans and documentation gaps. This will enable targeted quality improvement actions.

All complaints will be acknowledged, investigated, and resolved where possible to the satisfaction of the complainant in line with the centre's policy and the regulations. Learnings will be shared with staff and quality improvement plans put in place and monitored. There will be sufficient evidence in place to reflect this

A full audit of all staff files will be conducted to ensure they meet Schedule 2 requirements. Recruitment and HR procedures will be strengthened to maintain complete documentation for all current and new staff.

The risk register will be updated immediately to include all identified risks, with clear controls and mitigation actions documented. Ongoing weekly risk reviews will be scheduled as part of the governance review to prevent future incidents, especially regarding residents with high supervision needs.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Training will be provided to all staff on the complaints policy, including what constitutes a complaint and mandatory documentation steps.

The management team will review complaints weekly as part of the weekly governance meeting to ensure compliance and quality assurance.

Satisfaction surveys will be completed with Residents and or their representatives to ensure all complaints are captured.

The management team will ensure all complaints are acknowledged, investigated, and resolved where possible to the satisfaction of the complainant in line with the centre's policy and the regulations. Learnings will be shared with staff and quality improvement plans put in place and monitored. There will be sufficient evidence in place to reflect this.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
The provider will ensure all discharges are planned collaboratively with the resident and relevant parties. A formal discharge protocol will be implemented requiring documented agreement before discharge proceeds.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All Residents will be thoroughly assessed using the comprehensive risk assessment prior to admission. All preassessments will reflect the residents care needs and this will be discussed and agreed prior to the resident being admitted. Should the need for extra resources be required on admission theses will be approved by the registered provider.

Assessments will be completed within 24 hours of admission.
Care plans will be developed within 48 hours of admission based on thorough assessments.
Post admission Audits will be completed within 48 hours to ensure compliance with the regulations.

All care plans will be promptly reviewed and updated following any change in residents' health or social needs to ensure safety and support needs are met. A check list will be developed on the electronic to ensure compliance.

A tracking system to alert the care team of required care plan reviews will be enhanced.

Training of all nursing and care staff on timely assessment, documentation, and updating of care plans.

The Person in Charge will audit to monitor compliance and address any gaps promptly, as part of her governance reporting.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Separate bank accounts for residents' funds are now fully established and monitored to prevent financial abuse. All relevant payments are redirected accordingly, with ongoing audits by management.

No staff are permitted to start without valid Garda vetting and without gaps in the recruitment process; files audited and compliance strictly enforced. Each new staff file will be signed off by the PIC, prior to their commencement date.

All staff have completed safeguarding vulnerable adults training. Additional training and refresher sessions are scheduled to enhance understanding.

Procedures are in place to ensure all potential safeguarding concerns, including financial ones, undergo timely preliminary screening, full investigation and reporting to the necessary bodies as per policy.

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 14(1)(a)	The registered provider shall ensure that the designated centre has a person in charge.	Not Compliant	Orange	04/08/2025
Regulation 14(6)	A person who is employed to be a person in charge shall have not less than 3 years' experience in a nurse management role in the health and social care area.	Not Compliant	Orange	04/08/2025
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 residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	09/07/2025
Regulation 16(1)(a)	The person in charge shall	Not Compliant	Orange	15/07/2025

	ensure that staff have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	17/07/2025
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.	Not Compliant	Orange	31/08/2025
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	31/08/2025
Regulation 25(4)	A discharge shall be discussed, planned for and agreed with a resident and, where appropriate, with their family, and in accordance with the terms and conditions of the contract agreed in accordance with Regulation 24.	Substantially Compliant	Yellow	01/06/2025
Regulation 34(2)(b)	The registered provider shall ensure that the complaints	Not Compliant	Orange	17/07/2025

	procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	17/07/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a	Not Compliant	Orange	17/07/2025

	designated centre.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/08/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	17/07/2025
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	15/07/2025