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:	Glengara Park Nursing Home
Name of provider:	Glengara Park Nursing Home Ltd
Address of centre:	Lower Glenageary Road, Dun Laoghaire, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	05 March 2025
Centre ID:	OSV-0000044
Fieldwork ID:	MON-0045853

About the designated centre

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

Glengara Park Nursing Home can accommodate 66 residents, both male and female. Residents are over the age of 18 years with varying conditions, including dementia, cognitive impairment, physical, neurological and sensory impairments. Residents with end of life and mental health needs are also accommodated. Twenty four hour nursing care is provided.
Glengara Park Nursing Home is a purpose built nursing home composed of 62 single and two double bedrooms. Each room is fully decorated and furnished. Residents are encouraged to bring personal belongings and small items of furniture where appropriate. The majority of the rooms have en-suite facilities. There is one large sitting room and one large family room situated on the ground floor. Other sitting areas around the house include a coffee dock, an activities room. Outdoor facilities include two large patio areas, one of which is secure. A sensory garden is accessible at the front of the Nursing Home.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

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 5 March 2025	09:30hrs to 18:00hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

The inspector spent time observing and speaking with residents, staff and visitors to gain insight into the lived experience of residents living in Glengara Park Nursing Home. The overall feedback from residents was that they were content living here. Staff were observed to be familiar with the residents' preferred daily routines, care needs and the activities that they enjoyed. Residents spoken with said staff are very kind and caring. While residents were very complimentary of staff a small number of residents expressed their opinion that staff were sometimes "overprotective" and described how anytime they tried to stand-up and leave a communal room they were told to sit back down so they do not fall. Following on from the previous report in May 2024, residents said that there had been some improvements in the length of time they had to wait for care to be provided, however, they felt like this could still be improved on further.

On arrival to the centre, the inspector met with the group quality and clinical practice lead, person in charge and assistant director of nursing (ADON). Following this, the person in charge and ADON accompanied the inspector on a tour of the centre.

The centre is set out over three levels and is a custom-built facility located in Dun Laoghaire. It is registered to accommodate a maximum of 66 residents in 62 single and two twin occupancy bedrooms, which were located on each level of the centre. Many residents had personalised their rooms with personal possessions and photographs. One twin occupancy bedroom and 58 single occupancy bedrooms had an en-suite with a toilet and hand-wash basin. Residents in the remaining bedrooms had access to shared communal toilets.

Residents had access to a range of communal areas on each level. There was a large bright dining room located on the lower ground floor, with a smaller multi-purpose room adjacent to this, which was also used as a dining room. The dining room had floor to ceiling windows and doors that opened out onto a secure garden area which residents could access. There was also a coffee dock located on the lower ground floor which also opened out onto a secure patio area, however, the there was no coffee or tea making facilities available in this area and it was lacking in decoration to create an enjoyable space for residents to use.

Communal space on the ground floor consisted of a family room which was pleasantly decorated and a sitting room where activities took place. These rooms were located across from each other, next to the nurses station and supervised by staff. Residents also had a library on the first floor, which families also used at times when visiting their loved ones. These rooms were seen to be clean, bright and comfortable and tastefully decorated, with residents art work hung in one sitting rooms. There was also some open seated areas off corridors on all levels. On the day of inspection, the first floor open seated area was being used as a hair salon. This was a hive of activity with many residents availing of this and saying how

grateful they were to have this service available to them.

On the day of inspection, activities took place in the family room and sitting room on the ground floor. In the morning, five residents were making pottery in the family room and showing the inspector different pieces they had created. In the sitting room, where there was a larger number of residents with activity staff, there was no scheduled activity taking place. In the afternoon, some residents were observed to enjoy an exercise class with activity staff in the family room and residents in the sitting room, watched television.

Residents were also observed to be accessing chiropody and physiotherapy assessments on the day of inspection.

On the previous inspection in November 2024, the large storage spaces on the first floor were observed to be over-filled with items, which impacted on the premises and fire safety of the centre. The registered provider had begun work to reorganise this area and remove the items stored in this area. The inspector was informed that the storage area would be divided into three and re-organised with new metal shelves and flooring.

The inspector observed the dining experience at lunchtime, which had two sittings to facilitate all residents who required assistance. A smaller group of residents dined in the multi-purpose room with the larger group of residents eating the the dining room. Other residents chose to eat in their bedroom, which was aligned with their will and preference. Residents who required assistance were observed to receive this support in a respectful and dignified manner. Dining room tables were set and dressed with fresh flowers. Menus were available on each table for residents to choose between two options for their meal. Residents spoken with were complementary of the food served, with one resident saying the food was "excellent" and it is "good everyday".

In general, visitors spoken with were happy with the care provided to residents, and spoke about how caring staff were to residents. Some visitors spoken with expressed their opinion that there had been staff shortages, however, felt that this had started to "settle" and there was less of a staff turn over currently.

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

Overall, the inspector found that repeated changes to the senior management team had impacted the service in a number of areas to ensure the service was safe, consistent and of a good quality, this is detailed under each regulation. While there were established management structures in place in the centre, the management

team were new to their roles and needed time to establish themselves while developing robust oversight systems to ensure all aspects of the service met residents needs, and were in line with the regulations. This included ensuring there were sufficient staff at all times, that residents assessments and care plans were meeting the needs of residents and ensuring meaningful activities for the number and interests of the residents living in the centre. Some improvement was also required in respect of training and staff development, managing responsive behaviours and infection control.

This was an unannounced risk-based inspection to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013), carried out by one inspector over one day. This inspection also followed up on solicited and unsolicited information received since the inspection in May 2024.

Glengara Park Nursing Home limited is the registered provider for Glengara Park Nursing Home. Over the previous year there has been several changes to the person in charge role, with five different person's in charge over this period. A new person in charge had just commenced their role two days before the inspection. There had also been further changes to the senior management structure with a new group quality and clinical practice lead in the role since February 2025. In addition, the assistant director of nursing (ADON) was new to the position since January 2025 and one of the clinical nurse managers (CNM) was new to the role since February 2025. The person in charge reported to the group quality and clinical practice lead, who in turn reports to the group director of operation.

The clinical management team consisted of a person in charge, an assistant director of Nursing (ADON) and two clinical nurse managers (CNM). The person in charge also had oversight of a team of nurses and healthcare staff, activity staff, chefs, a catering and domestic team, administration, and maintenance staff.

The registered provider had audit and monitoring systems in place to oversee the service covering areas such as, care plans, infection prevention and control, call-bell response, restraint and wounds, which were completed monthly. The provider also had systems to oversee accidents and incidents within the centre. While there were systems in place, they had not effectively identified key areas for improvement and implement plans that would affect change and improve the service provided.

Meetings were held and minuted to cover all aspects of clinical and non-clinical operations, however, there had been some gaps in the occurrence of these scheduled meetings due to changes in senior management. The person in charge also completed weekly reports covering all clinical and non-clinical aspects of the centre and sent this to the registered provider. The registered provider also met with the person in charge on a monthly basis to provide oversight of the centre.

Improvements were observed in the completed annual report for 2024 and it was evident that the report had been completed with resident feedback and family input. There was also a quality improvement plan in place for 2025 which had identified some of the findings from this inspection.

Following on from the inspection in May 2024, the registered provider had made changes to the skill mix of staff in the mornings, to ensure that the staffing arrangements were having regard to the needs of residents. Night duty staff were no longer preparing residents breakfast, the chef was now scheduled to start work at 7am and kitchen assistants were scheduled on duty from 7.30am, allowing staff on night duty to attend to the care needs of residents. The registered provider had made substantial efforts to fill vacancies, and there were no vacancies in the clinical management team on the day of inspection. However, the majority of them were new to the role. In addition to this, from a review of records, the inspection found that there had been a high turnover of staff in all positions since the last inspection, and this impacted on the quality of care provided, which is outlined under Regulation 5: Assessment and care plan and Regulation 9: Residents' rights. For example, there was a turnover of 28% of nursing staff, 38% of healthcare assistants, 100% of activity staff and 58% of domestic staff.

Staff had access to appropriate training and development to support them in their respective roles and a training schedule was in place. All staff had completed safeguarding training and three new staff were due to complete fire safety training, which was scheduled. Additional training had been identified as required following the inspection in May 2024, for example, care planning. While this had been completed, findings from this inspection were that further training may be beneficial; new staff who had not completed care plan training were scheduled to attend this also. The registered provider had also committed to all staff completing refresher training on managing behaviour that is challenging, which was also completed.

Regulation 15: Staffing

The registered provider had worked hard to recruit vacant roles and made changes to staff skill mix in the mornings. However, 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. While residents acknowledged that they had observed some improvements since the last inspection, some residents told the inspector that, at times they still had to wait for a prolonged period of time before they received the care requested. Observations of the inspector on the day of inspection, were that there were some delays to answering call-bells, with some call-bells responded to after five minutes from when resident's sought assistance. The registered provider had also completed a call-bell review in January 2025 and identified some residents waiting over 10 minutes for staff to attend to a residents' call-bell when requesting assistance.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Notwithstanding the fact that mandatory training was provided and up-to-date for all staff or scheduled to occur in the coming weeks, this inspection found that further training and supervision was required in assessment and care planning, this is detailed under Regulation 5: Individual assessment and care plan.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established a directory of residents for the centre, which was electronically maintained with all Schedule 3 information recorded.

Judgment: Compliant

Regulation 23: Governance and management

While the provider had management systems to monitor the quality and safety of service provision, these oversight systems were not fully effective to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. For example:

- There were similar repeat findings from the May 2024 inspection in relation to Regulation 5: Individual assessment and care plan. For example, some care plans were not reviewed in line with the residents changing needs. This is further details under the regulation.
- A review of the schedule of activities was required to ensure that all residents across the centre had opportunities to participate.
- While the registered provider had taken action to improve staffing arrangements, further oversight was required to ensure the staffing arrangements having regard to the size and in particular the layout of the designated centre were appropriate to meet the needs of all residents. This is detailed in Regulation 15: Staffing.
- The systems in place to ensure oversight of the use of restraint did not fully ensure that where restraint was used, that it was used in accordance with the national policy.

Judgment: Substantially compliant

Quality and safety

The inspector observed kind and compassionate staff treating the residents with dignity and respect, as described above. However, this inspection identified areas where improvements were required to ensure a good standard of care and support was provided to residents. Specifically in relation to, resident's rights, assessment and care planning, managing behaviour that is challenging and infection control.

The person in charge had arrangements for assessing residents before admission into the centre. Validated assessment tools were used to assess the needs of residents. Care plans were in place and were reviewed at regular intervals, not exceeding four months. While some good practice was observed in care planning, some care plans were not always reviewed and updated in line with the assessed needs of residents. This is further detailed under Regulation 5: Individual assessment and care plan.

A restrictive practice register was in place, which had been reviewed and there was evidence that efforts were being made to try reduce the use of restraints in the centre. There was a use of restraint policy in place and a policy for residents with responsive behaviours. Care plans for restrictive practices were in place, however, these were not developed in line with the centres own policy. In addition, the inspector was not assured that where restraint was in use, that it was being implemented in accordance with the national policy.

In general, residents' choices and preferences were seen to be respected. The inspector saw that staff engaged with residents in a respectful and dignified way. Residents had access to independent advocacy services, with advocacy service details on display in the centre. Residents also had access to newspapers, radio, television and internet services. Residents were consulted with about their individual care needs and residents' meetings were held regularly, with a good level of attendance by residents. While activities were available to residents, it was limited in the options it offered. For example, some of the activities offered could only facilitate a small numbers of residents, like pottery, which those residents said they enjoyed. However, the inspector observed lengthy periods of time where some residents were observed sitting in communal areas without other meaningful activation.

A sample of medication management charts were examined. The systems in place were safe and staff had a good knowledge of safe medication management, which was observed by the inspector during this inspection. The medication management policy was available, up-to-date and included information in relation to safe prescribing, storing, dispensing, shared medications, and administration of medicines.

While the centre was generally clean and tidy on the inspection day, some cleaning and storage practices required review to minimise the risk of transmitting a healthcare-associated infection. This will be discussed under Regulation 27.

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018). However, some cleaning and storage required review. For example:

- Some fabric-covered chairs in the corridor on garden floor were seen to be stained and torn.
- A sink in a sluice room was observed to be dirty and stained, which posed an increased risk of cross-contamination.
- The large storage area on the top floor was seen to be unclean. In addition, boxes were stored on the floor, which would impact effective cleaning practices. Clinical equipment, for the use of residents, was seen to be stored with non-clinical items. This may also pose a risk of cross-contamination.
- Some drying racks in sluice rooms were seen to be dirty, with cleaned clinical equipment drying on them.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medication management processes such as the ordering, prescribing, storing, disposal and administration of medicines were safe and evidence-based.

The inspector observed good medication administration practices. A sample of medication administration charts were reviewed and these were comprehensive. Nurses administered medication from valid prescriptions.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Similar to inspection findings from May 2024, this inspection found that some residents' assessments and care plans were not always reviewed and updated in line with the assessed needs of residents. For example:

- Two residents' who were identified as a high risk of falls, did not always have their assessments and care plans reviewed following recent falls. This meant that their documented assessment of need and care plan, in place to guide staff in the management of this risk, did not appropriately guide staff practice to reduce the risk of falls.
- Care plans were not always implemented, this is a repeat finding from the

May 2024 inspection. For example, a resident was required to have a bed sensor alarm in place, as per their care plan, due to their high risk of falls. On a review of records, although the sensor was in place, it was recorded as not working or not alarming staff to the resident having had a fall, with no record of any actions taken to rectify the sensor.

- Care plans were not always developed using a comprehensive assessment. For example:
    - A resident was required to have hourly safety checks due to their high risk of falls. However, this was not documented in their care plan. On review of the records, there were also gaps of up to seven hours with no safety checks recorded.
    - Residents' had completed assessments for their psychosocial well-being and recreation. However, the care plans in place were not individualised to meet the assessed needs of the residents'. This impacted the type of activation provided to residents with some residents records demonstrating limited or no activities provided to them.
- Restrictive practice care plans were in place for residents with responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). However, these were not developed in line with the centres own policy and did not clearly guide staff in safe care delivery.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Where restraint was used in the centre, it was not always used in accordance with the national policy. On a review of records, there was no evidence that trails for alternative, less restrictive measures before an episode of restraint were initiated. Action was also required concerning the monitoring of residents' safety during an episode of restraint when bedrails were in use. On reviewing the safety check records, the inspector noted that these were not consistently carried out hourly as required by the provider's policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

On the day of inspection, activities took place in the family room and sitting room on the ground floor. There were two activity staff available, with an activity schedule in place. However, the activities available to residents offered limited options. For

example, five residents were making pottery and there was no alternative scheduled activity for the larger remaining residents. There was an over-reliance of passive activities like watching television, and the inspector observed lengthy periods of time where some residents were observed sitting in communal areas without other meaningful activation. Feedback from residents in residents surveys and residents meetings, was that they would like more activities planned aligned with their interests. In addition, from a review of records, the inspector observed that some residents had limited or no activities recorded as being provided to them.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 27: Infection control	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Glengara Park Nursing Home OSV-0000044

Inspection ID: MON-0045853

Date of inspection: 05/03/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• The PIC in consultation with the RPR, assumes ongoing responsibility for ensuring that a staff roster is compiled weekly, reflective of appropriate number and skill mix of staff, whilst simultaneously ensuring that at all times staffing is in line with the Statement of Purpose and the layout of the centre

• The clinical requirements and dependency level of each individual resident remains subject to ongoing review. This information is used to inform and adjust staffing levels accordingly

• The PIC in collaboration with the Senior Clinical Management Team now monitors call bell activity as part of their daily walkarounds – as a component of this review live call bell data is also examined.

• The PIC in collaboration with the Clinical Management Team has increased the frequency of call bell audits, with any deficiencies identified actioned and resolved in a timely manner

• The PIC and the Clinical Management Team have reiterated the fundamental importance of reactive, responsive, and appropriate care interventions to staff during unit meetings - specific reference and significance has been placed on the necessity for prompt tending to call bells.

• A Quality of Interaction Schedule (QUIS) has been commissioned by the PIC to assess the quality, promptness and appropriateness of interactions between staff and residents.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Since the previous inspection a training needs analysis has been conducted by the Group Quality & Care Manager in collaboration with the PIC. All nurses working in the centre have subsequently been tasked with attending refresher care plan training workshops.

• The PIC has commissioned a review of the induction process to ensure that core care plan content is covered as a topic for new staff

• The PIC has implemented a key staff allocation list for care plans to ensure that responsibilities are assigned to relevant personnel and to facilitate enhanced oversight.

• The PIC maintains oversight of care plan audits, the same of which are completed at regular intervals with any deficiencies identified promptly addressed through the initiation of robust action plans overseen by the PIC and the Clinical Management Team.

Regulation 23: Governance and management	Substantially Compliant

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

• The PIC in consultation with the RPR, assumes ongoing responsibility for ensuring that a staff roster is compiled weekly, reflective of appropriate number and skill mix of staff, whilst simultaneously ensuring that at all times staffing is in line with the Statement of Purpose and the layout of the centre

• The clinical requirements and dependency level of each individual resident remains subject to ongoing review. This information is used to inform and adjust staffing levels accordingly.

• Since the last inspection, arrangements have been made by the PIC in collaboration with the Clinical Management Team, to undertake a review of the assessment and care planning processes within the centre to ensure they are person centred and reflective of the current status and preferences of each resident.

• The PIC has met with nursing staff and reminded them of the fundamental importance of ensuring that care plans are devised in a person centred manner, in accordance with assessment content and reviewed at four monthly intervals or more frequently as

dictated by an alteration in the resident's clinical status and/or expressed preference

• Based on ongoing feedback and input from the residents, the content of the activity schedule has since been revised by the Activities Team. Emphasis has been placed on ensuring that activities are more meaningful and aligned with the expressed preferences of the residents

• Both the Clinical Management and Activities Team oversees that residents are facilitated to attend and participate in activities in line with their request and/or preferences on a daily basis

• The Group Quality and Care Manager in collaboration with the PIC has initiated a review of all restrictive practices utilised in the centre to ensure that the least restrictive practice is used only as a last resort where trialled alternatives are deemed unsuitable or inappropriate. All restrictive practices within the centre are used for the shortest duration possible and their use subject to continuous and ongoing review in consultation with the resident and/or their nominated representative and the multidisciplinary team.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• The Clinical Management Team conducts daily walkarounds at regular intervals to maintain supervision and oversight with respect to IPC practices in the centre.

• The Clinical Management Team has initiated a review of the current storage facilities to ensure appropriate segregation of clinical and non-clinical equipment.

• The frequency of cleaning both in sluice rooms and in the large storage area on the top floor has since been increased in response to the inspection findings.

• The boxes which were noted to have been on the floor of the storage area on the top floor on the date of the inspection have since been removed.

• The PIC has commissioned a review of all chairs in circulation to assess feasibility of cleaning and/or repair(s) as appropriate. Any chairs subsequently deemed unsuitable or unfit for purpose have been condemned accordingly and replaced.

• PIC has reviewed the cleaning schedule and new amended forms are now in place for the clinical areas, resident's space, storage and communal areas.

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:

• Since the last inspection, arrangements have been made by the PIC in collaboration with the Clinical Management Team, to undertake a review of the assessment and care planning processes within the centre to ensure they are person centred and reflective of the current status and preferences of each resident.

• The PIC has met with nursing staff and reminded them of the fundamental importance of ensuring that care plans are devised in a person centred manner, in accordance with assessment content and reviewed at four monthly intervals or more frequently as dictated by an alteration in the resident's clinical status and/or expressed preference.

• A training needs analysis has been conducted by the Groups Quality Manager in collaboration with the PIC. All nurses working in the centre have subsequently been tasked with attending refresher care plan training workshops.

• The PIC has commissioned a review of the induction process to ensure that core care plan content is covered as a topic for new staff

• The PIC has implemented a key staff allocation list for care plans to ensure that responsibilities are assigned to relevant personnel and to facilitate enhanced oversight.

• The PIC ensures that care plan content is enacted by maintaining oversight of care plan audits, the same of which are completed at regular intervals with any deficiencies identified promptly addressed through the initiation of robust action plans overseen by the PIC and the Clinical Management Team.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• The PIC of Glengara Park remains committed to promoting a restraint free environment so far as is reasonably practicable.

• The Group Quality and Care Manager in collaboration with the PIC has initiated a

review of all restrictive practices utilised in the centre to ensure that the least restrictive practice is used only as a last resort where trialled alternatives are deemed unsuitable or inappropriate. All restrictive practices within the centre are used for the shortest duration possible and their use subject to continuous and ongoing review in consultation with the resident and/or their nominated representative and the multidisciplinary team.

• Since the previous inspection, the PIC has organised unit meetings with staff and reminded them of the importance of ensuring that appropriate safety checks are conducted when a restrictive practice has been initiated.

• The Clinical Management Team have been tasked with ensuring that documented evidence is maintained that resident safety checks are being completed on a daily basis when a restrictive practice is utilised.

• Restrictive practice audits continue to be completed at regular intervals with any deficiencies arising from the same actioned accordingly. A restrictive practice committee has also been established to further enhance oversight.

• The PIC has further tasked staff with completing training with respect to restrictive practices and has recirculated the restrictive practices policy to staff to read and acknowledge their responsibilities pertaining to the same.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Group Quality Care Manager and PIC has met with the activities team and relayed the importance of ensuring that there is evidence that activity schedules are devised in consultation with residents.

• Based on ongoing feedback and input from the residents, the content of the activity schedule has since been revised by the Activities Team. Emphasis has been placed on ensuring that activities are more meaningful and aligned with the expressed preferences of the residents.

• The revised activity schedules are now reflective of choice. Documentation is maintained for all residents reflecting resident input and engagement, with oversight in this regard maintained on a daily basis by the Clinical Management Team.

• Both the Clinical Management and Activities Team oversees that residents are facilitated to attend and participate in activities in line with their request and/or preferences on a daily basis.

• Residents friendly activity information board is now in place on 3 floors and 2 lounge

areas. Activity coordinator update this on a daily basis.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/03/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2025

Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	23/05/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/04/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/04/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only	Substantially Compliant	Yellow	30/04/2025

	used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/04/2025