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:	Carrigoran House
Name of provider:	Carrigoran House
Address of centre:	Carrigoran, Newmarket-on-Fergus, Clare
Type of inspection:	Unannounced
Date of inspection:	20 October 2025
Centre ID:	OSV-0000445
Fieldwork ID:	MON-0047219

About the designated centre

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

Carrigoran House is a two storey purpose built facility located in Newmarket-on-Fergus, Co Clare. Established in 1974 the centre is owned and managed by The Sisters of Charity of the Incarnate Word. The ground and gardens surrounding the home provide opportunity for residents to relax and walk in a safe and secure environment. As per the Statement of Purpose the centre aims to provide a safe, secure and caring environment for persons requiring residential care in the catchment area. The centre is registered to accommodate 109 residents in single and double bedrooms. The centre is divided into four units. St Joseph's and St Oliver's unit are located on the first floor and St Theresa's and St Mary's are located on the ground floor. Each unit is staffed separately and has a nursing station, kitchenette, sitting room and dining space.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	105

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
Monday 20 October 2025	09:30hrs to 19:00hrs	Una Fitzgerald	Lead
Monday 20 October 2025	09:30hrs to 19:00hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

Resident's living in Carrigoran House were complimentary of the staff who provided them with care and support in a caring and respectful manner. Residents spoke positively about staff as individuals who made them feel safe, and described how staff encouraged them to be independent and to engage socially through activities and with other residents. However, some residents expressed discontent with some aspects of the service and told inspectors that there had been a "deterioration" in the service over the last short months. Residents attributed this to the high turnover of staff and reported that staff did not always know their individual needs and wishes. Residents were quick to defend the staff as individuals but were clear that they felt there was insufficient numbers of staff on duty each day and night delivering the care.

Inspectors arrived at the centre unannounced and were met by the management team. Following an introductory meeting, inspectors walked through the premises. Inspectors met with a number of residents during the walk around the centre, and spoke to a number of residents in detail about their experience of living in the centre. Some residents were unable to articulate their views on the quality of the service they received. Those residents appeared to be comfortable in the communal dayrooms throughout the day of inspection.

There was a busy atmosphere in the centre during the morning. Staff were observed attending to residents requests for assistance with their morning care in their bedrooms, and engaging with residents in a person-centred manner. Inspectors spoke with a number of residents in their bedrooms. Residents were complimentary in their feedback about the staff and described their engagements with staff as kind, respectful and caring. Residents acknowledged how busy the staff were and described how this impacted on the care they received. Residents repeatedly told inspectors about the high turnover in staffing. When asked how this impacted them, residents told inspectors that not all staff knew their needs.

Residents told inspectors that staff were generally responsive to their requests for assistance. Residents described how they would wait long periods of time for assistance. Residents reported that they would often experience delays in going to bed or waiting to be assisted to mobilise around the centre. Residents reported that, while the wait was unwelcome, staff were very apologetic when this occurred. Residents told inspectors that they were acutely aware that the staff were under pressure and at times this influenced them to not call for assistance.

Residents reported that they were satisfied with their bedroom accommodation, and further satisfied with the storage facilities for their personal possessions.

Ongoing maintenance was in place. While the centre was observed to be clean in areas occupied by residents, there were two sluice rooms that were not cleaned to

an acceptable standard. This included sinks and equipment, used to decontaminate toileting aids, that were visibly unclean. Equipment used by residents, such as urinals were visibly unclean. This created a risk of cross contamination, and therefore a risk of infection to residents.

Throughout the day of inspection, residents were observed to be engaged in a variety of group activities. Some residents preferred to remain in their bedroom throughout the day. Multiple residents remained in communal rooms on the units. In one unit, inspectors observed on multiple occasions that residents were unsupervised for long periods. When staff were asked about the supervision of the room they confirmed that there was no person allocated to the supervision of the room. The staff competed spot checks in between attending to the care needs of other residents. There was no activity held in this room and outside of the residents receiving assistance with their meals, no social interaction was observed for the residents who remained in the room throughout the day.

Residents were provided with opportunities to express their feedback about the quality of the service through scheduled resident meetings and through individual conversations with the management. However, residents told the inspectors that their feedback was not always acted upon in a timely manner. For example, residents had provided feedback in September 2024 with regard to the availability of staff but felt that their feedback and concerns had not been addressed.

Residents were provided with information about the services available to support them, such as independent advocacy services.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being 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). Inspectors reviewed notifications submitted by the provider in relation to adverse incidents involving residents, with the management of unexplained absence of residents from the centre.

Overall, the inspectors found that the registered provider had failed to ensure that there were sufficient resources in place to effectively deliver care to residents. Additionally, the systems of management and oversight in place to communicate key information to staff, to monitor the management of complaints and the quality and safety of care to residents were not adequate, These deficits were found to impact

on residents' safety and residents' choice. This inspection found that the centre was moving away from compliance with the requirements of the regulations.

Carrigoran House is the registered provider of the centre. The chief executive officer (CEO) worked full time in the centre to support the person in charge and had responsibility to oversee non-clinical areas of the service. The person in charge worked in the centre on a full-time basis and was supported in their role by an assistant director of nursing (ADON), who deputised in their absence, as well as three clinical nurse managers, nursing staff, health care assistants, administration staff, catering, housekeeping, activities staff and maintenance staff. Lines of responsibility and accountability were clearly outlined.

Inspectors found that the organisation and management of staffing resources was not effective, and that this adversely impacted the quality of care delivered to residents. Records demonstrated that the centre's staffing levels had recently been impacted by an increase in staff turnover. In response to this, the provider had ongoing recruitment in place. On the day of inspection the planned roster was not maintained which left a shortfall of two healthcare assistants to deliver the direct care to residents. Furthermore rosters evidenced multiple days whereby the staffing compliment on the floor was reduced with staff not replaced when they were unavailable to work. Feedback from residents and staff supported the finding that residents were not always provided with assistance in a timely manner. For example; in one unit, staff confirmed that residents who wished to remain in the communal rooms as opposed to attending the large group activities were not supervised, as observed on the day of inspection. The impact of the staffing shortages is outlined under Regulation 15: Staffing.

The inspectors reviewed a sample of staff files. The files contained the necessary information, as required by Schedule 2 of the regulations, including evidence of a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Records reviewed confirmed that training was provided through a combination of in-person and online formats. All staff had completed role-specific training in safeguarding residents from abuse, manual handling, infection prevention and control, the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) and fire safety. Each staff member completed an induction process on commencement of working in the centre and were supported by working with a member of staff.

Although there was a good level of training provided to staff, inspectors observed that there were ineffective systems of supervision in place. For example, not all staff on commencement of their day received an update on the current healthcare status of the residents under their care. This posed a risk as staff had not received information on new admissions. Furthermore a number of staff allocated to provide care to residents were not familiar with their specific care needs such as the requirement for increased supervision and the requirement to ensure intake of fluids was monitored as per the care plan direction. Therefore, staff were not

appropriately supervised to implement the care plans and maintain accurate records which would evidence the care provided to residents.

The management team had identified that a number of residents who were at high risk of absconsion and therefore required increased levels of supervision. Inspectors found that the systems in place to monitor the residents at risk was inadequate. The control measures set out in a risk register which was completed by senior managers was not always known to staff working on the units delivering direct care and therefore risk mitigating measures were not fully implemented by staff at unit level. Records reviewed by the inspectors demonstrated that risk assessments were not always completed following incidents of unexplained absence. Records of location checks were incomplete or had significant gaps. Furthermore, staff responses regarding the level of supervision required for some residents and frequency of location checks required were inconsistent. This did not provide assurance that residents received the supervision required, to ensure their safety and well-being.

Some notifiable incidents, as detailed under Schedule 4 of the regulations, were not notified to the Chief Inspector of Social Services within the required time-frame. For example, the Chief Inspector had not been notified of incidents with regard to the unexplained absence of a resident from the designated centre.

The management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner. Residents had voiced concerns with the high turnover of staff and the availability of healthcare staff to attend to their needs. Records demonstrated that resident concerns around staffing dated back to September 2024. On the day of inspection, multiple residents told inspectors that the staffing numbers delivering the direct care was inadequate. A review of the September 2025 records demonstrated that residents had again raised concerns with staffing levels. However, these concerns had not been recognised as a complaint and therefore had not been managed through the complaints process.

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:

- Multiple residents told inspectors that they were acutely aware of the staffing shortages in the centre and felt it was unfair at times to use their call bell seeking assistance. For example; a resident told inspectors that they had to wait over an hour each night to return to bed as there was only one nurse on duty with one heatlhcare assistant to meet the needs of 28 residents.
- on the day of inspection there was a shortfall of 16 hours of direct care.
- residents reported having to wait extended periods of time to have their call bell answered.

- rosters evidenced multiple days whereby the staffing compliment on the floor was reduced with staff not replaced when they were unexpectedly unavailable to work.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised. This was evidenced by;

- there was poor supervision of staff to ensure that policies and procedures in place to manage the unexpected absence of residents was implemented. For example, risk assessments were not always completed following the unexplained absence of a resident from the centre.
- residents clinical documentation, including the assessment of residents needs and care planning, to ensure they were accurate and up-to-date was not consistently completed.
- There was ineffective communication of key clinical information to healthcare staff to ensure care was delivered in line with the residents' individual assessed needs and care plans. For example, there were gaps in the completion of safety checks to ensure that staff knew where residents who were at high risk of absconsion were at all times. In addition, the completion of fluid monitoring charts as required due to a medical condition.
- There was inadequate supervision of staff to ensure that sluice rooms and resident equipment was clean.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to ensure that there were sufficient staffing resources in place to consistently maintain planned staffing levels in line with the current resident care needs and the centre's statement of purpose. This impacted on the overall governance and oversight of the service. The service was dependent on the staff working additional hours and to be available at short notice to support the rosters. This system is not sustainable. While there was evidence of ongoing recruitment, on the day of inspection the provider did not have the staffing resources to cover planned and unplanned leave.

The registered provider had failed to ensure there were effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored.

- Poor oversight and monitoring of incidents involving residents. As a result of those failings, a significant incident occurred whereby a resident with poor safety awareness left the designated centre unnoticed and unaccompanied. There was insufficient evidence that the incidents had been adequately reviewed or investigated to identify learning, and minimise any further incidents.
- there were ineffective auditing systems. For example, the call bell audit had not captured the voice of the residents. In addition call bell audits demonstrated that call bell response times were not audited when the staffing levels in the centre were reduced, such as night time. This incomplete information gathering impacted on the providers ability to appropriately monitor staffing levels in the centre.
- there were ineffective systems to ensure key clinical information regarding residents' care needs was effectively communicated to staff. While the majority of staff spoken with had been informed of incidents involving residents leaving the designated centre unaccompanied, not all staff demonstrated the required knowledge of some residents individual support needs to effectively manage the risks to residents.
- There was poor oversight of nursing documentation. A review of the quality of a sample of residents' care plans found that care plans were not based on the assessment of residents needs or risks. Care plans, particularly those relating to residents at risk of unexplained absence from the centre, were not based on assessment and did not reflect the current care needs of the residents. Therefore, care plans lacked the required detail to ensure residents received safe and effective person-centred care.

Judgment: Not compliant

Regulation 31: Notification of incidents

The registered provider had failed to notify the Chief Inspector of incidents occurring in the designated centre. Notification had not been submitted within three working days in relation to the unexplained absence of residents on four separate occasions.

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 availability of staff and the answering of call bells that had been brought to the attention of the management team through the resident meetings were not identified, appropriately documented or managed in line with the centre's complaints policy. Consequently, there was insufficient evidence of how these issues were acknowledged, investigated or resolved to the satisfaction of the complainant.

In addition, the provider had not provided training to the nominated complaints' officers to ensure that all complaints were managed in accordance with the centre's procedures.

Judgment: Not compliant

Quality and safety

A review of the governance and management systems on this inspection found that in the main residents in the centre received a good level of person-centred care on a day-to day basis, however, the systems in place on the management of risk, and steps taken by the provider to minimise further incidents, was not in line with regulation requirements and did not provide assurances that the resident were appropriately monitored at all times. Inspectors found that the monitoring of residents with a known history of unexplained absence from the centre was insufficient. These issues have been addressed within the 'capacity and capability' section of this report.

A sample of assessments and care plans for residents were reviewed. Some care plans described residents' care needs and personal preferences in a detailed and person-centred manner, while other care plans lacked the detail required to guide staff to deliver effective, person-centred care. The details of the findings are outlined under Regulation 5; Individual assessment and care planning.

Residents were reviewed by a medical practitioner, as required or requested. Referral systems were in place to ensure residents had timely access to health and social care professionals for additional professional expertise. Staff described how residents received ongoing support from visiting GP's and allied healthcare professionals including physiotherapists, dieticians and speech and language therapists (SALT).

The centre was actively promoting a restraint-free environment and the use of bed rails in the centre was minimal. Restrictive practices were only initiated following an appropriate risk assessment, and in consultation with the multidisciplinary team and the resident concerned.

Residents who required temporary discharge to an acute facility were transferred with all relevant documentation required by the receiving centre.

Residents reported that they felt safe living in the centre. A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse.

Visitors were observed in the centre on the day of inspection. Residents confirmed that there were no unnecessary restrictions in place.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Transfer letters to and from the centre were observed on review of residents care documentation. The documents reviewed ensured that the most relevant information was provided in accordance with the residents' current care needs.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A comprehensive assessment of need was not always completed, and consequently, appropriate care plans were not developed. For example:

- A nutritional assessment was not completed for a resident who was admitted to the centre with a pressure related injury, consequently a care plan was not developed to guide staff on the most appropriate interventions to support the residents nutritional needs and wound healing.
- Care plans developed for several residents who demonstrated exit seeking behaviours were not informed by an assessment of need.

A sample of residents' assessments and care plans reviewed by inspectors, found that they were not always 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;

- Two residents, who were assessed on admission as being at risk of falling did not have appropriate care plan developed.

Some residents' care plans were not reviewed in response to their changing needs. For example,

- Care plans were not always updated when there was a change in a residents condition or needs. For example, after an incidence of unexplained absences, were the residents supervisory needs had increased
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of a resident whose condition had significantly deteriorated had not been updated. Consequently, the care plan did not reflect the additional nursing interventions required to support their needs.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP).

Residents also had access to a range of health and social care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life and palliative care.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. A safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

The provider did not act as a pension agent for any residents living in the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Carrigoran House OSV-0000445

Inspection ID: MON-0047219

Date of inspection: 20/10/2025

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 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: • We had recruited 3 Healthcare Assistants in July prior to the inspection. Two have arrived and are orientating and we expect the third travel visa will be granted before the middle of December. • We readvertised on the 15th of October and have recruited a further four full time and two part time healthcare assistances they are due to start employment once Garda Vetting is through. • To cover any gaps in the interim we are utilizing one agency company to maintain continuity of staff and care. Also, we have two full time locum staff that are not rostered on any unit and are utilized to provided additional support to the units or to cover sick leave at short notice. • Roster completed 5 weeks in advance to try where humanly possible to ensure no shortfalls in the staffing compliment. • Completed Staffing review, hearing the 'voice of our staff' through questionnaires and interviews to identify cause of high turnover.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All registered nurses will update assessments and care plans on a daily basis where there is a change in the resident's condition. • On a weekly basis CNM's will do an audit of 10% of all assessments and care plans. Every four months the CNM's will do a comprehensive audit of all assessments and care	

plans.

• A new admission audit to be completed after 48 hrs by CNM to ensure that all necessary assessments and care plans are complete and accurate.

• When a resident absconds the absconsion risk assessment will be updated following the incident. The absconsion list is available in all departments so all staff are aware of residents who are at risk of absconding.

• Learning outcomes will be identified.

• To ensure effective communication of key clinical information we will introduce the 'Safety Pause'. This will happen after report every morning to discuss the key clinical needs of the residents such as Infections, Highs Falls Risks, absconsion list, Safety Checks and Fluid Monitoring. Staff arriving on duty at 9am will receive handover from the nurse before commencing duty.

• Housekeeping staff will sign a Daily Sluice Room Check and this will be audited by the Housekeeping Supervisor on a weekly basis.

• There is a cleaning schedule for residents' equipment which is signed. This is audited weekly by the Senior Healthcare Assistant and signed off by the Clinical Nurse Manager.

Regulation 23: Governance and management	Not Compliant

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

• We had recruited 3 Healthcare Assistants in July prior to the inspection. Two have arrived and are orientating and we expect the third travel visa will be granted before the middle of December.

• We readvertised on the 15th of October and have recruited a further four full time and two part time healthcare assistances they are due to start employment once Garda Vetting is through.

• To cover any gaps in the interim we are utilizing one agency company to maintain continuity of staff and care. Also, we have two full time locum staff that are not rostered on any unit and are utilized to provided additional support to the units or to cover sick leave at short notice.

• Roster completed 5 weeks in advance to try where humanly possible to ensure no shortfalls in the staffing compliment.

• Completed Staffing review, hearing the 'voice of our staff' through questionnaires and interviews to identify cause of high turnover.

• When an incident occurs, it will be adequately reviewed and investigated to identify any learning outcomes to minimise any further incidences.

• The call bell audit has been reviewed and amended to capture the voice of the resident, summary of findings and any follow up action that may be required.
• All registered nurses will update assessments and care plans on a daily basis where there is a change in the resident's condition.
• On a weekly basis CNM's will do an audit of 10% of all assessments and care plans. Every four months the CNM's will do an audit of all assessments and care plans.
• A new admission audit to be completed after 48 hrs to ensure that all necessary assessments and care plans are complete and accurate.
• When a resident absconds the absconsion risk assessment will be updated following the incident. The absconsion list is available in all departments so all staff are aware of residents who are at risk of absconding.
• One staff member on the unit will be allocated to do safety checks on residents that are assessed as risk of absconsion. When these residents leave the unit to attend their daily activities such as mass and activity room the activity coordinator will continue these safety checks. When activities are finished the resident will be escorted back to the care of the unit staff. These safety checks will be logged on documentation system and audited on a weekly basis by CNM's.
• Post any incident the DON will complete a full review/ investigation will be conducted to identify learning and to minimise any further incidents.
• To ensure effective communication of key clinical information we will introduce the 'Safety Pause'. This will happen after report every morning to discuss the key clinical needs of the residents such as infections, high fall risks, absconsion list, Safety Checks and Fluid Monitoring. Staff arriving on duty at 9am will receive handover from the nurse before commencing duty.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
When a resident is deemed a missing person, the Chief Inspector shall be notified.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All staff will complete the online Effective Management of Complaints training. Complaint forms readily available at reception and in the supervisor book.

• All complaints are reported at the Quality and Safety Department meetings and the

Clinical Nurse Manager meetings. Learning outcomes are then shared with all department staff.

• Following resident forum meetings all issues, concerns and complaints will be dealt with in line with our complaints policy. They will be acknowledged investigated and resolved to the satisfaction of the complainant to the greatest degree possible.

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 registered nurses will update assessments and care plans on a daily basis where there is a change in the resident's condition.

• On a weekly basis CNM's will do an audit of 10% of all assessments and care plans. Every four months the CNM's will do an audit of all assessments and care plans.

• A new admission audit to be completed after 48 hrs to ensure that all necessary assessments and care plans are complete and accurate.

• The Director of Nursing will formally review all care plans at intervals of not more than 4 months.

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	20/01/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/12/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	20/01/2026

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	30/11/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	24/11/2025
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	24/11/2025
Regulation 34(7)(a)	The registered provider shall ensure that (a)	Not Compliant	Orange	20/01/2026

	nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	14/11/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	20/01/2026