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:	St. Dominic Savio Nursing Home
Name of provider:	Smith Hall Limited
Address of centre:	Cahilly, Liscannor, Clare
Type of inspection:	Unannounced
Date of inspection:	05 February 2026
Centre ID:	OSV-0000450
Fieldwork ID:	MON-0049585

About the designated centre

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

St. Dominic Savio nursing home is a purpose-built single-storey nursing home that provides 24-hour nursing care. It can accommodate up to 28 residents both male and female over the age of 18 years. Care is provided for people with a range of needs: low, medium, high and maximum dependency. It is located in a rural area close to the coastal village of Liscannor. It provides short and long-term care primarily to older persons. There are nurses and care assistants on duty covering day and night shifts. Accommodation is provided in both single and shared bedrooms. There are separate dining, day and visitors' rooms as well as a garden patio area available for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	27

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 5 February 2026	09:00hrs to 16:15hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in St. Dominic Savio Nursing Home spoke positively about their experience of living in the centre. Overall, residents expressed high levels of satisfaction with the quality of care provided, access to health care services, staffing levels, and staff support. Residents also reported satisfaction with the quality and variety of food they received, and the range of activities available to them. Collectively, residents described that these factors contributed to them feeling safe, valued, and respected while living in the centre.

The inspector arrived unannounced at the centre and was met by a clinical nurse manager. The person in charge was on statutory leave at the time of the inspection, and a clinical nurse manager was deputising in their absence. The inspector completed an initial walk-around of the centre, met with residents and staff, reviewed the premises and care environment, and observed staff and resident interactions throughout the inspection.

The inspector met with all residents and spoke in detail with seven residents about their experience of living in the centre. Some residents were from the local community and reported that they were familiar with both the staff and the surrounding area. Other residents had moved to the centre from outside the locality and were complimentary of the care they received. One resident stated that they could not fault the quality of the service provided and described being supported to make choices about their daily routine, including what time they wished to get up, the clothes they wished to wear, and how they spent their day. Residents reported that they knew staff well and that consistent staffing contributed to staff knowing residents' individual needs and preferences, which enhanced the quality of care provided. Another resident spoke positively about their admission to the centre and reported that they were made to feel welcome from their first day. They stated that staff took time to get to know them and that their family was also made to feel welcome when visiting.

Overall, the premises was well-maintained, clean and comfortable for residents. The centre was appropriately furnished and maintained to a good standard throughout. Residents spoke positively about their bedroom accommodation. The inspector observed that some bedroom doors did not have an option for residents to lock their doors, and that locks on two bathroom doors were not functioning. Residents had access to outdoor garden areas and spoke very positively about the physical environment, in particular the views of the sea, which were described as enhancing residents' enjoyment of the centre. One resident described how, on a previous evening, they had spent time with fellow residents admiring the sky reflecting red light across the water, which they found very enjoyable.

Some fire safety concerns were observed on the walk around the centre. These related to the inappropriate storage of equipment within the electrical and heat

distribution room, and to service penetrations through the ceiling in this area, where gaps were observed that had the potential to compromise fire containment. The provider commenced addressing these issues during the inspection.

Residents were served their lunch in the dining room and in their bedrooms. Residents stated that they were offered choice at mealtimes and were very complimentary regarding the quality of food provided. Meals were observed to be appetising and well-presented. Residents, who required assistance, were attended to by staff in a dignified, relaxed and respectful manner.

A dedicated member of the staff was allocated to provide activities, morning and evening, seven days a week. A daily schedule of activities was displayed on a notice board in the communal area. The notice board also displayed information for residents on independent advocacy services and safeguarding services. Residents were observed to be actively engaged in a range of activities during the inspection. This included group activities such as singing and music, as well as engagement in individual activities for person enjoyment, such as art-based activities.

Visiting was not restricted, and a number of visitors were observed attending the centre on the day of inspection. Visitors expressed a high level of satisfaction with the quality of care provided to their relatives, and described the management and staff as approachable.

The following sections of this report details the findings with regard to the capacity and capability of the provider, and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

The findings of this inspection were that St. Dominic Savio Nursing Home was generally well managed, with systems in place to support the monitoring of the quality and safety of care provided to residents. It was evident that management and staff were focused on delivering a quality service and promoting residents well-being. While governance and oversight arrangements were in place, the inspector found that some management systems were not consistently or effectively implemented to ensure full regulatory compliance. This was evident in aspects of record management, the quality of residents' care plans, safeguarding arrangements, communication of clinical information about residents, and risk management processes to identify and mitigate risks that may impact on residents' safety and welfare.

Smith Hall Limited is a company comprised of two directors and is the registered provider of this centre. Both directors were actively involved in the day-to-day

operation of the centre, and provided governance and support to the person in charge.

There was an established and well-resourced nurse management structure in place within the centre. The person in charge was supported by three clinical nurse managers. The clinical nurse manager role included providing clinical and administrative support to the person in charge, along with delegated responsibility for the supervision of the quality of the service and the provision of direct nursing care to residents. Arrangements were in place to ensure appropriate deputising during periods of leave of the person in charge, and these arrangements were in effect on the day of inspection.

While a nurse management structure was in place, this inspection found that responsibility for certain aspects of oversight of the service was not always clearly defined. In the absence of the person in charge, nurse managers did not always have sufficient awareness or knowledge of information required to support consistent oversight of the service. This included information relating to risks to residents, incidents, and aspects of record management and care planning processes. As a result, some aspects of the coordination and supervision of care were not fully effective. This included the communication of key clinical information to staff providing care to residents, such as residents' nutritional care needs, which posed a potential risk to ensuring residents assessed needs were consistently met in a person-centred manner.

Systems were in place to support the monitoring of the quality and safety of care through a programme of clinical and non-clinical audits. In addition, weekly monitoring of key clinical performance indicators was undertaken, including wounds, incidents, transfers to hospital, and infections. These monitoring arrangements were effective in supporting oversight of residents care, and in monitoring trends in the quality of care provided to residents. For example, where an increase in issues such as falls was identified, this prompted review by the person in charge of relevant aspects of the service, including staffing resources, access to specific training, and care practices to address the issues identified.

Records relating to staff personnel files were appropriately maintained and well-organised. All staff files reviewed contained evidence of Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act. However, not all records were maintained in line with the requirements of the regulations. This included information required to be maintained within the directory of residents, records relating to the management and outcome of complaints and safeguarding concerns, and records of the nursing care and treatment provided to residents. In particular, records relating to residents' nutritional care and wound care did not consistently demonstrate comprehensive oversight of care delivered.

Arrangements were in place to record, investigate and learn from incidents that occurred in the centre. There was evidence that incidents were reviewed, and efforts were made to identify contributory factors, and that learning from incidents was shared with staff. While all incidents were investigated, the inspector found that

one incident, required to be notified to the Chief Inspector, was not notified in line with regulatory requirements.

Systems were in place to support the management of risk within the centre. These systems were informed by a policy and procedure, and a risk register was maintained by the provider. However, the inspector found that risk identification was not always comprehensive. Some known risks identified on the day of inspection had not been previously identified or recorded by the management team. In particular, risks such as residents with high supervision requirements leaving the centre unaccompanied, had not been appropriately identified or recorded.

Adequate staffing resources were in place to meet the needs of residents. Staffing levels were appropriate on a daily basis, with suitable skill-mix of nursing, health care and support staff. Staff turnover was low and staffing arrangements were stable, which supported continuity of care and enabled staff to develop good knowledge of residents individual needs and preferences. Adequate support staff, including catering and housekeeping personnel, were also in place to support the effective running of the centre.

Effective systems were in pace to monitor and assess staff training needs. Staff training was tracked and monitored using a newly implemented electronic system, which evidenced that all staff had completed the training required to support them in their roles. A programme of training was in place for 2026, and there was also a quality improvement plan to increase the provision of face-to-face training and reduce reliance on online-based training, to further support staff development and practices.

Arrangements were in pace to support the supervision of staff. Nurse managers were available to direct and oversee care delivery, and were also observed working alongside staff, providing guidance and support, as required.

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of residents, in line with the statement of purpose. There was sufficient nursing staff on duty at all times, and they were supported by a team of health care staff. The staffing compliment also included catering, housekeeping, administrative and management staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff demonstrated appropriate knowledge with regard to the safeguarding of vulnerable people, fire safety, and manual handling. Staff had also completed additional training to support the provision of safe and person-centred care to residents. There were arrangements in place for the ongoing supervision of staff through senior management presence, and through formal induction and performance review processes.

Judgment: Compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not always in line with the regulatory requirements. For example;

- Records of complaints did not always contain details of the action taken by the registered provider in response to a complaint, in line with Schedule 4(6) of the regulations.
- The directory of residents did not contain all the information required by Schedule 4(3)(g). Records in relation to the the date, time, and cause of death of a resident were not consistently recorded.

Some records were not maintained in a manner that was accessible.

Judgment: Substantially compliant

Regulation 23: Governance and management

Lines of accountability and responsibility for the monitoring and implementation of key management systems were not always clearly defined. In particular, it was unclear who held responsibility for ensuring effective oversight of record management, risk management, residents' assessments and care plans, and ensuring associated review processes were carried out.

Management systems in place were not always effectively implemented to ensure that the service provided was safe, appropriate, consistent and subject to effective monitoring and oversight. For example;

- Communication of key clinical information about residents care needs to staff was not always effective, which impacted on the delivery of person-centred care to residents. For example, staff were not always informed of changes to residents dietary requirements, or risks associated with their medical conditions.
- Risk management systems were not always effective in identifying and managing environmental and clinical risks. For example, the heat distribution

room, which also contained electrical fuse boards, was observed to be unclean and cluttered with stored items. In addition, three were gaps in the wall around service penetrations.
- Management oversight and monitoring of adverse incidents involving residents did not ensure that an incident was appropriately notified to the Chief Inspector, as required.
- The systems in place to manage and access records was not robust. For example, in the absence of nominated staff members, access to some key records was not possible, and the systems to monitor records to ensure full compliance with the regulations was poor.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A notification was not submitted to the Chief Inspector in line with the requirements of the regulations. An event that met the threshold for notification was not reported within the required time-frame.

Judgment: Not compliant

Quality and safety

Residents care needs were met to a satisfactory standard. Residents reported that they felt safe living in the centre, and arrangements were in place to safeguard and protect them from the risk of harm or abuse. Residents' rights were respected and upheld, and they were supported to engage in activities that promoted their well-being and quality of life. However, residents individual assessments, and the care plans informed by them, did not always accurately reflect residents' needs, and the provision of nutritional care did not consistently ensure that meals provided were aligned with residents' individual requirements.

All residents had a pre-admission assessments completed in advance of the resident moving into the centre to ensure that their assessed needs could be met. A review of a sample of assessments, used to inform the development of person-centred care plans, found that some assessments were inaccurate and did not fully reflect residents' actual care needs. In addition, care plans were not always reviewed or updated in response to changes in resident's conditions. The inspector also found that care plans were not consistently developed within the required time-frame following admission, as set out in the regulations.

Residents' health care needs were met through unrestricted access to general practitioner services, who attended the centre, as required or requested. Residents also had access to a range of allied health and social care professionals for specialist assessment and intervention, including dietetic services, speech and language therapy, physiotherapy and occupational therapy. These services were accessed through an established referral process.

Residents' nutritional care needs were assessed on admission to the centre, and at regular intervals thereafter. Residents' weights were monitored on a monthly basis, or more frequently, if indicated. Meals were pleasantly presented and appropriate assistance was provided to residents during meal-times. Residents had choice for their meals and menu choices were displayed for residents. However, the inspection found that meals were not always prepared in a manner that fully reflected residents' individual dietary needs. This included residents who required low calorie and low sodium diets.

There were arrangements in place to safeguard and protect residents from the risk of abuse. A safeguarding policy detailed the roles and responsibilities of staff, and the appropriate steps to take, should a concern arise. All staff spoken with were clear about their role in protecting residents from abuse.

Residents' rights were protected and promoted in the centre. Choices and preferences were seen to be respected. Regular residents' meetings were held, which provided a forum for residents to actively participate in decision-making and provide feedback for a variety of areas of the service provision.

There were adequate facilities available to deliver activities to residents, and there were adequate opportunities to participate in meaningful activities.

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 18: Food and nutrition

Meals provided did not always meet residents' individual dietary needs as identified through nutritional assessment and prescribed by health care or dietetic professionals. For example;

- Two residents who required low-fat or low-calorie diets did not receive meals or portion sizes in line with their care plans to support appropriate management of their weight.
- One resident was not provided with a required diabetic diet, as prescribed by a health care professional.

In addition, information required to support appropriate meal preparation was not consistently communicated to staff responsible for preparing residents meals. As a result, staff were not always aware of residents' specific dietary requirements, including therapeutic diets and information relating to residents experiencing weight loss.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessment and care plans found that they were not fully in line with the requirements of the regulations. For example;

- An appropriate assessment of risk and care plan was not completed in a timely manner following a residents' admission to the centre, despite a known risk of impaired skin integrity. As a result, staff did not have clear guidance about the required management and preventative interventions necessary to protect the residents from the risk of developing a pressure related injury.
- Care plans were not guided by a comprehensive assessment of a residents care needs. A resident's care plans did not adequately reflect the needs of the resident and did not identify appropriate interventions in place to support a resident who had significant complex behavioural care, supervision and support needs.
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of some residents who had experienced weight-loss had not been reviewed or updated following a change in their nutritional care needs. Consequently, their care plan did not reflect the nursing and medical 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) and GPs were visiting the centre, as required.

Residents were provided with timely access to a range of health and social care professionals. This included tissue viability nurse experts, psychiatry of later life, and palliative care services.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff, and a safeguarding policy provided support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that residents' rights were upheld in the centre and their privacy and dignity was respected. Residents were consulted for their feedback on the quality and safety of the service. There was evidence that issues arising in residents forum meetings were appropriately actioned.

This included requested changes to the menu, and the overall quality of the service they received.

Residents were provided with meaningful activities seven days per week. Records captured each residents involvement and level of participation in scheduled activities.

Information pertaining to independent advocacy services was prominently displayed in the centre. Residents could access the services independently through a system of referral or independently though telephone.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. Dominic Savio Nursing Home OSV-0000450

Inspection ID: MON-0049585

Date of inspection: 05/02/2026

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Records of Complaints – A review of the current management of records of complaints, both on computerized documentation programme and paper, to be completed. Our current complaint monitoring audit tool will be developed further to ensure that it reflects actions taken by registered provider in response to each complaint. The initial audit and development of audit tool will be completed within 8 weeks of inspection. An audit of open complaints and concerns will take place weekly/monthly and quarterly to ensure that up to date information regarding complaint is available. Feedback and learning for all concerns and complaints will be given to staff through staff briefings and daily safety pause. Directory of residents - A copy of schedule 3 (3) has been placed on the Directory of Residents to guide nursing staff when making entries into the Directory of Residents. – The directory of residents will be reviewed and missing information will be added as far back as information is available. Records not maintained in a manner that was accessible. - A full review of all records set out in Schedule 2, 3 and 4 to ensure that all records are available and accessible will be completed. This review will be completed within 12 weeks of Inspection date with a quarterly review to ensure ongoing compliance.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Ensuring a clearly defined management structure that identifies lines of accountability, specifies roles and details responsibilities for all areas of care provision. The centre's organogram has been reviewed and made available for all staff with additional discussions with staff, with a particular focus on CNMs, to ensure their understanding of	

lines of accountability, specific roles and details of responsibilities. Weekly briefings between Registered Provider and PIC have been reintroduced with the aim of increased ongoing communication to ensure effective oversight of record management, risk management, residents' assessments and care plans and ensuring that Quality Improvement Plan and Management Priorities are being developed and delivered. Minutes for weekly meetings between Provider and PIC will be kept for continuity and accountability. This compliancy plan was implemented 02.03.2026.
Ensuring management systems are in place to provide a safe, appropriate, consistent and effectively monitored service- In relation to the communication of key clinical information. A review is currently underway of our residents' dietary requirements as follows: Phase 1 – a review of medical records has been completed to identify key clinical information that may impact on dietary requirements. Phase 2 – Referral of residents with identified medical conditions to Dietician completed.
Phase 3 – Dietician review of all residents with identified medical conditions completed.
Phase 4 - Updating of care plans and the development of a notification board for the catering department that identifies residents requiring specialist diets due to medical conditions ongoing. Phase 5 - Development of menu to cater for medical conditions requiring dietary changes ongoing.
Phase 6 - Auditing of information to ensure up to date list available of residents with dietary requirements is available. Rapid identification of all new admissions who have medical based dietary requirements – Ongoing. This project is currently operational with the final phases to be established within 8 weeks of Inspection. Effective risk management systems - The heat distribution room has been added to our environmental audit list. A risk assessment detailing the risks of the heat distribution room has been completed. The heat distribution room has been cleaned, gaps repaired and items removed. Our current risk register is newly developed. This is on a quarterly review system. Current risks will be reviewed for requirement of further detailing during quarterly reviews. The risk that was highlighted during inspection has been reviewed with additional risks added to it. The review of our current risk register will be completed by the end of April.
The management, oversight and monitoring of adverse incidents to ensure that incidents are appropriately notified to the Chief Inspector - The PIC acknowledges that the suspected incident highlighted by the Inspector was notifiable within 2 days. Going forward any incidents that are suspected to have occurred or cause uncertainty for PIC and those deputizing will be notified to the Chief Inspector with the information updated as the investigation progresses or until the concern is resolved. The Proprietor has given access to the HIQA Portal to the CNMs so that they may submit notifications in the absence of the PIC. This compliancy plan was commenced immediately following inspection. Ensuring robust systems for managing and accessing records. As part of our digitalized documentation roll out which commenced in 2023, we continue to improve our management and accessing of records. As part of our Quality Improvement Plan for 2026, we plan to have our records systems streamlined so that all data, where it is possible, is available in a digital format and there is minimal paper documentation. A system review will take place to ensure the clear signposting for all records as per Schedule 3 and 4. The anticipated date for completion of system review is 31.06.2026. Additionally, increased auditing of records to ensure compliancy with regulations has been introduced. Examples of this are; auditing of resident's care plans by PIC using an audit tool which is in development. An oversight audit for ensuring that

current audits that are in place are completed was developed for roll out in 2026. A weekly clinical matters document is in development to ensure ongoing communication of clinical matters. Additionally, the documentation for new admissions, from admission enquiry, through to pre-admission assessment and admission assessment has been reviewed and updated to ensure that the information captured for each resident is done in a timely manner, ensuring that all staff have knowledge of risks and the care plans for each new resident. The impact these changes make will be monitored and a further review will take place in 3 months to test efficiency

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Having reviewed the incident relating to this non-compliance, the PIC acknowledges that that this incident met the threshold of requiring notification. Going forward any incidents that are suspected to have occurred or cause uncertainty for PIC and those deputizing will be notified to the Chief Inspector with the information updated as the investigation progresses or until the concern is resolved. The registered provider has given access to the HIQA Portal to the CNMs so that they may submit notifications in the absence of the PIC. This compliancy plan was commenced immediately following inspection.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

Ensuring that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.
Ensuring that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual plan of the resident concerned.
.A review is currently underway of our residents dietary requirements as detailed under Regulation 23, the review scope was to capture nutritional information in addition to the current monitoring of residents MUST scores and medical diagnosis of diabetes, to include those who have high BMI or have other medical conditions that could be impacted by diet. Residents with dietary issues have been referred to dietician for further support and their recommendations implemented following assessment of each resident. At the time of completion of this compliancy report, the Centre is developing menus in accordance with dietician's recommendations and updating each residents' care plan. A white board has been utilized in the food preparation area to ensure that information

regarding residents' dietary needs is communicated to all staff. To ensure capturing of dietary information of new admissions our admission assessments have been updated. The newly developed clinical matters document will strengthen the Centre's oversight of Food and Nutrition by ensuring weekly review of clinical information.
The full roll out of the systems to ensure compliancy with Regulation 18 will be completed within 12 weeks of Inspection date.

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:

Ensuring that a comprehensive assessment is completed either immediately before or on admission for each resident and care plans are developed in response to these assessments. Ensuring that care plans are reviewed and updated in line with changing residents' conditions.
CNMs and PIC have completed "Care Planning for the Older Person" course to enhance our care planning skills. This course will be completed by our nursing team also, with planned completion for all nursing staff within 10 weeks of inspection date.
A weekly clinical matters document has been developed which includes a checklist to give assurance that all documentation for new admissions, including care plan development, is completed within the required time frame of 48 hours. Additionally, this document will conduct an audit of resident records to ensure compliance with regulations and quality standards, allowing Person in Charge (or person deputising for her) to formally review all residents' care plans. Additionally, this document aims to strengthen oversight for all nurse clinical matters, including review of care plans in line with residents' changing conditions. The Person in Charge (or the person deputizing for her) will be responsible for the implementation, review and dissemination of information this document contains. This document will be complimented by our audit document which monitors and ensures the 3 monthly review of each resident's individual assessments and care plans. The full roll out of the mentioned document to ensure compliancy with Regulation 5 will be completed within 12 weeks of the Inspection date.

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 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/04/2026
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	30/04/2026

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.	Substantially Compliant	Yellow	02/04/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	02/04/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	02/04/2026
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.	Substantially Compliant	Yellow	02/04/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in	Not Compliant	Orange	10/02/2026

	charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
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 designated centre.	Substantially Compliant	Yellow	30/04/2026
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.	Substantially Compliant	Yellow	30/04/2026
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	Not Compliant	Orange	30/04/2026

	the resident concerned and where appropriate that resident's family.			