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:	Anna Gaynor House
Name of provider:	Our Lady's Hospice and Care Services DAC
Address of centre:	Our Lady’s Hospice & Care Services, Harold's Cross, Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	22 May 2025
Centre ID:	OSV-0000465
Fieldwork ID:	MON-0047195

About the designated centre

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

Anna Gaynor House is a designated centre in south Dublin city which provides full time nursing care and support for up to 89 adult male and female residents. Residents are supported in single, twin and triple occupancy bedrooms across four units in a single storey building. The service provides care primarily for residents who require a high level of care. The centre avails of modern resources to promote and provide appropriate care and facilities for its residents. Residents are supported by a team of qualified nursing and support staff with centre management based on-site. Residents living in this service have on-site access when required to clinical services including geriatrician, physiotherapist, dietitian and occupational therapist. The centre premises includes large communal living and dining areas as well as multiple external courtyards and gardens on the site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	83

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 22 May 2025	07:35hrs to 16:10hrs	Sarah Armstrong	Lead
Thursday 22 May 2025	07:35hrs to 16:10hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

Overall, residents in Anna Gaynor House told inspectors that they were very happy with their living conditions and were complimentary of the standards of care and support they received. Inspectors spoke with 11 residents during the inspection, to get their feedback on the service provided. Throughout the day of inspection, inspectors observed interactions between residents and staff to be positive, kind and courteous. There was a calm and relaxed atmosphere in the centre and a respectful approach to care provided to residents. In particular, residents spoke highly of the staff who supported them, stating that the staff were "very kind" and "quick to help me when I need it". Residents also told inspectors how satisfied they were with the food in the centre. One resident told inspectors that there was "always plenty and its always lovely". Inspectors spoke to one resident who had lived in Anna Gaynor House for a number of years. This resident told the inspectors that moving into the centre was a big change for them at the time, but that they "love it here".

Inspectors observed that residents were supported to express their individuality in the centre, for example, residents were seen to have their make-up and hair nicely done to their preference, and residents told inspectors that they choose their own clothes each day. Residents bedrooms were personalised to residents' individual tastes. They had pictures of the residents on the bedroom door and made reference to residents' special interests such as ballroom dancing or the football club they support.

Residents also expressed their satisfaction with the range of activities on offer in the centre and the activity schedule was clearly visible for residents on each unit. The residents had recently formed a choir named 'The Chancers' and this was particularly enjoyed by residents. One resident told the inspectors "I can't sing but I love listening to the choir and their lovely music". Inspectors observed residents' art work displayed on the walls of the corridors. The centre recently celebrated the Bealtaine Festival and this celebration involved residents creating arts and crafts and featured a performance by the residents choir. Inspectors also observed a 'remembrance wall' to honour the memory of residents who had died.

Residents had access to various courtyards throughout the centre. The outdoor spaces were well maintained and had flower boxes with colourful and aromatic plants which provided a sensory experience for residents. Courtyards had plenty of seating for residents to sit and enjoy the outdoors. Inspectors observed that the doors leading to these courtyards were alarmed as a security alert to staff, but they were not locked which made the courtyards easily accessible for residents should they choose to go outside unaccompanied.

In talking with residents, inspectors asked if they knew who to speak to if they weren't happy with an aspect of the service they received. Residents expressed an understanding of the complaints process in the centre but those spoken with said they have never had to make use of it. One resident told inspectors "I would be the

first to complain, but I have never had to!". Notice boards were displayed throughout the centre on each unit with information available to residents. This information included details on the complaints process and how to access advocacy and safeguarding services. Inspectors also observed 'About us' notice boards on each unit, which invited feedback from residents and families through a 'tell us what you think' process. Notice boards also provided for information and updates for residents and families under 'did you know' and 'you said, we listened' sections.

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 on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

Overall, inspectors found that the registered provider provided a good standard of care and support to the residents living in the centre. The provider had arrangements in place to ensure that the centre was adequately resourced to deliver care in accordance with the centre's statement of purpose. However, improvements were required to the oversight systems in place to ensure the service was safe and effectively monitored.

This was an unannounced inspection carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated centres for Older People) Regulations 2013 (as amended).

Our Lady's Hospice and Care Service DAC is the registered provider for the designated centre. There was a clearly defined management structure in place with responsibility for the delivery and monitoring of good quality, safe care to residents. The management team consisted of a person in charge who is also the assistant director of nursing for the centre. The person in charge works full time in the centre and is supported in their role by a director of nursing and a team of clinical nurse managers. Staff nurses, healthcare assistants, activities coordinators, household, catering and maintenance staff make up the remainder of the staff team.

Staff had access to appropriate training, some of which was facilitated online and other training was attended in person. However, there were no processes in place to monitor and determine if staff implement their training in practice. This is further discussed under Regulation 16: Training and staff development.

Records set out in schedule 2, 3 and 4 were kept in the designated centre and made available to the inspectors on the day of inspection. Processes were in place to ensure that records were archived and retained for the time frames required as per the regulations. However, record management within the units required further

oversight to ensure they were kept in a safe manner. This is further discussed under Regulation 21: Records.

Complaints were found to be well managed by the person in charge. There was a clear policy in place for the management of complaints and this was displayed in prominent locations around the centre. Staff and residents spoken with were aware of this policy and what to do if making, or receiving, a complaint. Inspectors reviewed the centre's complaints log and found that complainants received prompt responses to their complaints in line with the requirements of the regulations. The person in charge had identified learnings from complaints and implemented actions to inform quality improvement going forward.

Regulation 15: Staffing

The registered provider had ensured the number and skill mix of staff was appropriate to meet the needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The registered provider had not ensured that staff were appropriately supervised or that staff were informed of the Health Act 2007 or the regulations made under it.

- There were no records of regular supervision or annual performance reviews completed with staff, and there were no processes in place to evaluate the effectiveness of training and staff development.
- Staff who spoke to the inspectors were not familiar with the Health Act 2007, or where to find a copy of the Act in the centre. Staff were unaware of how the regulations relate to the service they provide.

Judgment: Substantially compliant

Regulation 19: Directory of residents

Inspectors reviewed the electronic directory of residents which contained the required information specified in the regulations.

Judgment: Compliant

Regulation 21: Records

Not all records were kept in such a manner as to be safe. For example;

- Resident medical records were seen stored on shelves and on the counter at the nurses station which was accessible to all staff and visitors on the corridor
- Medical records which required archiving were piled on top of filing cabinets
- Cabinets for medical records were left open when not in use meaning resident personal information was easily accessible to view

Judgment: Substantially compliant

Regulation 23: Governance and management

Oversight systems in place did not ensure that the service provided was consistent and effectively monitored. For example;

The registered provider did not ensure appropriate monitoring of staff training, not all staff were up to date with required training such as fire safety, safeguarding and manual handling. For example;

- 31% of staff on the Mary Aikenhead and 15% on Benedict's units did not have updated fire safety training
- 19% of staff on Mary Aikenhead were not up to date with manual handling training.

There was poor oversight arrangements in place for the management of risks identified on the inspection. For example;

- Personal safeguarding risk assessments were not completed to identify residents who may be at risk of abuse
- Equipment such as mobility wheelchairs were seen charging in residents' bedrooms despite access to designated equipment storage areas, the registered provider had not identified this as a risk.
- Oxygen cylinders were stored in the Anna Gaynor Hall for residents who required oxygen during activities, however these cylinders were not secured to the wall and there were no signs to identify that oxygen was stored in this area. The registered provider had not identified this as a fire or safety risk.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notification of incidents as set out in the regulations were submitted to the Chief Inspector within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an accessible and effective policy in place for dealing with complaints which met the requirements of the regulations. The policy was displayed in prominent locations throughout the centre. Complaints were managed in line with the centres complaints policy and procedure. Residents and staff spoken with on the day of inspection understood what do do if they wished to make a complaint.

Judgment: Compliant

Regulation 4: Written policies and procedures

All policies and procedures as set out under Schedule 5 of the Regulations were in place in the centre. The registered provider had made these policies and procedures available to staff.

Judgment: Compliant

Quality and safety

Residents were found to receive good care and support by a kind and dedicated staff team. However, further improvements were required in relation to risk management, individual assessment and care plan and protection which will be further discussed under the respective regulations.

There were robust processes in place to identify, record and investigate serious incidents. Whilst there was a risk management policy and a risk register in place in the centre, risk management and assessments were seen to be carried out in isolation of the care planning process and did not identify the measures and actions in place to control the risks identified.

Although it was evident that care was delivered to a good standard, gaps were identified in the documentation of individual assessments and care plans. The inspectors reviewed 12 care plans and the findings varied across the different units. Residents had assessments completed within 48 hours following admission, however the care plans and review of the care plans were not always in line with the requirements of the regulations. This is further discussed under Regulation 5: Individual assessment and care plan.

Notwithstanding the processes in place to manage allegations of abuse further supervision of staff following completion of safeguarding training was required to ensure a proactive approach was taken to safeguarding residents at risk of abuse.

Residents told the inspectors that they felt safe living in the centre and that staff treated them with dignity and respect. Residents in the centre were of a variety of religious denominations and were satisfied with the arrangements in place for them to access religious services. Residents were also provided with access to daily newspapers, television and radio and were supported to exercise their right to vote.

Residents were provided with access to television in each of their bedrooms. Although residents in shared bedroom accommodation had access to their own individual televisions, these televisions were not equipped with audio facilities for private use. One resident in a triple occupancy room told the inspectors that there were no headphones for the TV in the shared rooms and that the noise from the other residents' TVs can be very loud and distracting, particularly where two or more are in use at the same time.

Residents had access to a good range of meaningful activities that were suited to their individual preferences and capacities. On the day of inspection, residents could chose to participate in activities including group sing-alongs, a music concert and individual activity sessions with staff to suit their needs. An activity schedule was displayed on each unit and residents were observed to be participating and enjoying activities on offer in the Anna Gaynor Hall in the afternoon of the inspection. Residents told the inspectors that they were encouraged to participate in the activities that were scheduled daily and they had various communal spaces should they choose to spend their time away from their bedroom. Other residents told inspectors that they preferred to spend some quiet time in their rooms and that staff respected their wishes.

Regulation 26: Risk management

There was a risk management policy in place which set out the process for identification and assessment of risks. However, on the day of the inspection the

risk register shown to the inspectors did not contain the measures and actions in place to control the risks identified on the risk register. For example;

- The risk register, provided on the day of inspection, contained two high rated risks, relating to issues with the call bell system and the TV system. These risks did not have identified measures and actions in place to control the risk.

The register did not contain the specified risks outlined in the regulations. These were submitted to the inspectors following the inspection, which were recorded as part of the local safety statement and completed as part of the health and safety risk assessment.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The registered provider and person in charge had not ensured that individual assessment and care plans reflect the specific health, personal or social care needs of the residents. For example;

- One care plan did not have the comprehensive assessment completed on the resident following admission. The communication details and personal information details were not completed on admission. The communication care plan was required for the resident as having moderately impaired visual difficulties, however the assessment and care plan did not identify the specific care needs of the resident.
- One assessment identified the resident as suffering with anxiety/restlessness and irritability but the section for potential triggers or interventions that help was not completed to inform the care needs of the resident.
- Two residents did not have their assessments and care plans updated in response to their changing needs. For example; one residents care plan for behaviours that challenge was last updated in May 2024. One care plan and assessment for a resident who recently received new manual handling equipment was last updated in April 2024.
- One resident who had a safeguarding plan in place following an allegation of abuse did not have an individual safeguarding risk assessment completed as a preventative measure.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a medical practitioner of their choice or who was acceptable to them, which included emergency cover for out of hours if required. Residents also had good access to other health and social care professionals including physiotherapist, occupational therapist, speech and language therapist and tissue viability nurse.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place to guide staff on measures to take to protect residents from abuse and staff received training in safeguarding vulnerable adults. However, the findings with regard to the oversight of proactive measures taken to safeguard residents from abuse is discussed under Regulation 23: Governance and management and Regulation 5: Individual assessment and care plan.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were provided with suitable facilities for occupation and recreation. A programme of activities was in place in the centre that reflected the interests and capacities of the residents. Residents had access to daily newspapers, television, internet and radio and were supported to exercise their right to vote. Residents were afforded choice in how they structured their days. Independent advocacy services were available to residents and residents were provided with information on how to access these services. Resident meetings were held on a regular basis in the centre and this afforded residents an opportunity to participate in the organisation of the designated 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 26: Risk management	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 Anna Gaynor House OSV-0000465

Inspection ID: MON-0047195

Date of inspection: 22/05/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant

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

CNMs to keep records of regular supervision of their staff which will be reviewed and evaluated by the PIC. Nurses use the HSELand digital PDP system.

Performance Development Plans (PDP) are already in place for staff nurses and Performance Achievement (PA) Reviews are in the process of being rolled out to all other staff over the course of the next 6 months.
Completion date: 21/01/2026

Plan to introduce the Kirkpatrick Model: Four Levels of Learning Evaluation to formally evaluate effectiveness and impact of staff training and development.
Level 1: Reaction (already completed – evaluation of training completed by staff (HSELand post course evaluation, in-person training evaluation forms, post education course evaluations).
Level 2: Learning (already in place - learning from Fire Training evaluated in PEEPs audit), training from other training or education sessions to be assessed in annual performance reviews (PDPs/PAs) and safety huddle staff led education spotlights to be introduced to close the learning cycle by passing on key learning from training and education programmes to their colleagues.
Level 3: Behaviour – peer review of training – behaviours and learning to be assessed during post falls evaluations, safeguarding screening, pressure ulcer reviews. Peer reviewed during SIMT (serious incident team reviews) during preliminary screening. Self-assessment during annual performance review.
Level 4: Results – Evaluation of unit data – incidents (pressure ulcer occurrences, falls, safeguarding, medication incidents, staff work related injuries) and nursing metrics to measure the impact of staff training and education.
All four levels fully implemented over six months
Completion date: 21/01/2026

Staff who spoke to the inspectors on the day were not familiar with the Health Act. A centralised location on each unit has been agreed for a copy of the Act and other guidance documents for staff. All new staff to the unit will be orientated to the location by their CNM and made aware of the content and the relevance to their practice.
Completed: 21/07/2025

Information sessions and bite size learning to be developed to ensure staff are aware of their role in ensuring compliance with the regulations.
Completion date: Ongoing/Continuous

Ensure updates to National documents or regulations are disseminated to staff at unit meeting or safety huddles.
Completion date: Ongoing/Continuous

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

There is a robust interdisciplinary process in place to ensure safety of healthcare records but following the recent inspection staff adherence on a daily basis requires improvement.

• Four monthly Universal Healthcare Record (UHCR) audits are already in place to assess storage capacity, record volume, policy compliance, and the physical condition of resident records.

• Unannounced GDPR compliance audits are carried out regularly by the Patient Services Team and the Data Protection Officer.

• A GDPR Internal Self-Audit for Paper-Based Patient Records Security is completed annually.

• Findings from all of the audits in place are disseminated to the ward managers to be conveyed to the staff and quality improvement plans put in place if required.

Enforcement of record safety to be championed by the CNMs of each unit on a daily basis and to be highlighted at weekly SAFE Huddle and at every ward round or MDT meeting.

Completion date: Ongoing/Continuous

Regulation 23: Governance and management	Substantially Compliant

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

Mandatory Training Trackers for each unit are reviewed on a montly basis by the PIC. Mandatory Training Compliance is a standing item on the PIC/CNM 1:1 meetings on a monthly basis. The CNMs on the wards are continuosly monitoring if training is implemented in practice. Fire Training knowledge is assessed during every fire drill and false alarm by the Fire Officer, ERT members and the PIC. Safeguarding knowledge and Childrens First Training is assessed by the safeguarding offficers when they are completing safeguarding preliminary screens and by the Nurse Tutors when they provide bespoke safeguarding training in the units when a need is identified at the MDT SAFE huddles.

A new digital Mandatory Training Tracking system is being rolled out currently which will have more reminders and prompts for managers and staff to ensure mandatory training is up to date. The training trackers are monitored by the Quality and Safety committee and the Executive Management Team on a monthly basis and additional external trainers are procured if the need for training slots exceeds what can be provided by the internal trainers. All Heads of Department (HOD) are responsible for ensuring staff compliance. External courses are not approved by the HODs unless staff have completed all of their mandatory training. This is included in the Learning, Training and Development application forms that are approved by the line manger, HOD and HR.
Completion date: 21/01/2026
An external company is being employed to provide blitz training dates in the coming months for Manual Handling to improve compliance rates. The CNMs on the units will monitor the implementation of training in practice on a weekly basis when providing care for residents with the staff. If there are any concerns regarding manual handling practice on the units the manual handling or if a staff member is reviewed in Occupational Health and requires assessment the inhouse trained manual handling instructors will do an observational assessment and issue a recommendations report. The MDT who attend the SAFE huddle on a weekly basis can raise any concerns reagarding changes in residents conditions and flag if any changes in manual handling techniques or manual handling is required.
Completion date: 21/10/2025

A pilot project is at the midway point in Mary Aikenhead. The project split the ward into two teams and introduced a CNM2 for each team to try to improve the mangement of the unit and the staff. The unit is the largest in Anna Gaynor House and has the biggest team of staff. There has been significant improvement in the first three months of the pilot so we will continue to ensure better oversight of staff training. The Director of Nursing is overseeing this pilot and will determine whether to submit a business case to the board if the trial is deemed sucessful. The CNM2s, CNM3 and PIC are monitoring the pilot on a monthly basis and making any necessary adjustments based on feedback from residents and staff.
Completion date: 31/10/2025

Personal safeguarding risk assessments and care plans to be completed for any residents who may be at risk of abuse. The CNMs, CNM3 and PIC will review these care plans on a monthly basis.
Completion date: 31/08/2025
Risk registers are reviewed monthly (or when a new issue arises).
All staff reminded to only charge wheelchairs in designated equipment storage areas.
The CNM3 and the CNMs on the units update the risk registers monthly. The Risk Officer collates the data from the risk registers and it is reported to Quality and Safety Committee on a monthly basis to ensure oversight. Any risks on the risk registers are also discussed at Executive Management Team meetings.
Completion date: 21/07/2025

Anna Gaynor Hall risk assessment review to be completed. Oxygen cylinders added to risk register while awaiting safety bracket to be installed. The Director of Non Clinical Services will ensure that any identified risks related to oxygen therapy are captured in the relevant risk register and will review on a quarterly basis.
Completed: 21/07/2025

Oxygen risk symbols placed on both doors of Anna Gaynor Hall. The Director of Non Clinical Services will ensure any area that keeps oxygen cyliners has the appropriate safety signage and will review on a quarterly basis.
Completed: 21/07/2025

Oxygen cylinder holder/wall bracket ordered. Awaiting supply and fitting. The Director of Non Clinical Services will ensure that all oxygen cyliners are appropriately secured and will review on a quarterly basis.
Completion date: 31/08/2025

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:

Risk register entries reviewed and updated to contain the appropriate measures and actions to control the risk.
Completed: 21/07/2025

The Risk officer, PIC and Quality & Patient Safety Lead to review the current process in place for the organisation under the Enterprise Risk Management policy to ensure that this also meets the specified risks outlined in the regulations.
Completion date: 21/10/2025

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:

Care plan liaison nurse to be introduced for a 6-month period to work with staff on the ward to ensure a comprehensive assessment is fully completed and reflects the residents needs and that appropriate care plans are established and tailored to the resident's needs. Care plans will capture a holistic view of the resident and will be designed in collaboration with them.
Completion date: 21/01/2026

They will work with nurses to review care plans when a resident's condition changes and ensure assessments and care plans are updated accordingly.
Completion date: Ongoing/continuous

Full documentation review to be completed within the 6 month period and recommendations for changes to documentation to be actioned.
Completion date: 21/01/2026

Staff nurses have been attending the Nursing Documentation & Care Planning Programme in Tallaght University Hospital which covers: Assessment in the care of older Person and Care Planning for Older Person. CNMs to send more staff nurses on the next course and any subsequent training dates available in our affiliated Centres for Nursing Education (Tallaght, St James and St Vincent's University).
Completion date: Ongoing Registered provider and PIC will ensure all residents have a comprehensive assessment completed following admission.
Completion date: 21/07/2025

Personal safeguarding risk assessments and care plans to be completed for any residents who may be at risk of abuse.
Completion date: 31/08/2025

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	21/01/2026
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Substantially Compliant	Yellow	21/01/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	21/07/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	21/01/2026
Regulation 26(1)(c)(vi)	The registered provider shall	Substantially Compliant	Yellow	21/10/2025

	ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control infectious diseases.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	21/10/2025
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	21/10/2025
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	21/10/2025
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5	Substantially Compliant	Yellow	21/10/2025

	includes the measures and actions in place to control accidental injury to residents, visitors or staff.			
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Substantially Compliant	Yellow	21/10/2025
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	21/10/2025
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).	Not Compliant	Orange	21/01/2026
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	Not Compliant	Orange	21/07/2025

	person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	21/10/2025