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 Joseph's Care Centre
Name of provider:	Health Service Executive
Address of centre:	Dublin Road, Longford, Longford
Type of inspection:	Unannounced
Date of inspection:	03 July 2025
Centre ID:	OSV-0000466
Fieldwork ID:	MON-0045617

About the designated centre

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

St Joseph's Care Centre provides 24-hour nursing care for up to 65 residents of all dependency levels, male and female, predominantly over 65 years of age. The centre can provide care to a range of needs of various complexity, including dementia care and cognitive impairment, acquired brain injury, palliative and palliative respite care. The centre is single-storey and comprises of two buildings containing five units. There are communal rooms and internal gardens available to residents as well as a large chapel. The centre's philosophy and motto is to 'add life to years when you cannot add years to life' and aims to address the physical, emotional, social and spiritual needs of all residents with a holistic approach of empathy and kindness. The centre is located in Longford town within easy reach of nearby shops and restaurants. Parking facilities are available on site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	54

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 3 July 2025	07:00hrs to 15:30hrs	Catherine Rose Connolly Gargan	Lead
Thursday 3 July 2025	07:00hrs to 15:30hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out over one day by two inspectors of social services. On arrival, the inspectors were met by night staff, and they completed a walk around all areas of the premises. This gave the inspectors the opportunity to observe residents' experiences of living in the designated centre, and to meet with staff, and to observe staff practices and interactions with residents. The inspectors observed that while some residents were awake and staff were attending to their needs, most of the residents were still sleeping.

During the day of this inspection, the inspectors spent time talking to ten residents living in the four units in the designated centre and five residents' family members who were visiting them on the day. The inspectors also spent time talking with night and day-staff working in the centre, observing their care practices and interactions with residents.

Residents' feedback on this inspection was mostly positive regarding their care, their quality of life in the centre, and the staff team caring for them. Residents told the inspectors that they 'liked living in the centre', and that 'the staff were very good' and 'I am well cared for here'. Some residents told the inspectors 'that staff were always close by' when they needed assistance, and that their food was 'absolutely lovely and plentiful'. One resident raised concerns about staff always being too busy to spend time talking with them, but expressed their satisfaction with staff attitudes and the standards of care and support provided by staff to meet their clinical needs. However, two residents expressed concerns to the inspectors that their safeguarding needs were not met regarding an interaction with a staff member and where a resident was entering another resident's bedroom uninvited during the night. The inspectors also observed and were informed about a number of other safeguarding concerns throughout the day regarding some residents' responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) that were not being appropriately responded to by staff to ensure these residents' dignity, psychological and quality of life needs were met.

In addition, during the inspection, staff members on duty shared their concerns with the inspectors regarding certain safeguarding incidents that they felt had not been adequately addressed. The inspectors reported these residents' concerns, as well as additional safeguarding issues they observed during the inspection, to the person in charge and the general manager of the centre. The provider was required by the inspectors to take urgent action to ensure each resident was adequately protected from the risk of abuse and to assure the Chief Inspector of Social Services that the provider had effective measures in place to ensure each resident's safeguarding needs were met at all times.

Residents' visitors told the inspectors that they were satisfied with the service provided and how their relatives were cared for in the centre. Two visitors told the

inspectors that communication with them and with the centre's local management team had improved.

Throughout the day of this inspection, staff interactions with residents were observed to be kind and caring. Staff took time to chat with residents, including during their care delivery, and the inspectors observed that residents were enjoying these interactions.

Residents who spoke with the inspectors had mixed views on their social care provision in the centre. Some residents spoke of enjoying group activities, such as live music and exercises, but wanted more activities. Some residents reported satisfaction with the opportunities for them to participate in individual activities, such as jigsaws and games. While other residents stated that no activities were taking place that catered to their interests. The inspectors observed that the scheduled social activities did not take place for residents in Our Lady's unit 1 (OLU1), and the inspectors were told by staff that the person with responsibility for facilitating residents' social activities was not available as they were accompanying a resident on a visit to their home in the community. In this person's absence, most of the residents, including a resident experiencing responsive behaviours, did not have an opportunity to participate in meaningful social activities as they wished, and they spent the time in their bedrooms.

Residents' bedroom accommodation was arranged on the ground floor level throughout in four separate units. Sunset and Autumn Lodge units were located in another building on an elevated site at the back of the main premises. The Lodge units were accessible via steps and a pedestrian sloped walkway. Handrails were fitted along both sides of the walkway and steps to support residents' safety. Our Lady's unit 1 (OLU1) and Padre Pio units were located in the building, but at a distance from each other. The circulation corridors within and outside of the units were wide enough for the passage of larger assistive equipment, such as large wheelchairs used by residents, and had handrails in place to support residents' independence and safety. The layout of residents' bedrooms, including multiple occupancy bedrooms with two, three and four beds in them, generally met residents' needs. However, the inspectors observed that as residents did not each have a television, two residents in a number of these bedrooms had to share a television, which did not support their choice of television viewing. The inspectors observed that many of the residents chose and were supported by staff and their families to personalise their bed spaces with their photographs and other personal items that were important to them. The communal dining rooms and sitting rooms were bright, spacious and well-decorated with traditional furnishings and memorabilia that were familiar to the residents. The inspectors observed that no residents were accommodated in the OLU 2 unit at the time of this inspection.

Overall, the general environment and residents’ bedrooms, communal areas, toilets and bathrooms were observed to be visibly clean. Appropriate storage for residents' assistive equipment and other ancillary facilities was available. Laundering of bed linen used by residents was outsourced to an external provider, and there was also a laundry on-site for laundering of residents`personal clothing.

The inspectors observed that residents could meet with their visitors privately outside their bedrooms or spend time in quieter areas such as the visitors' rooms or the assembly room in the reception area. The inspectors observed that the main doors to each of the units were open on this inspection, and residents could access the units and the enclosed external gardens as they wished. Measures had been put in place to ensure that access by members of the public in the centre was now controlled by staff.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This inspection found that management and oversight by the provider had not ensured effective care delivery and the quality and safety of the service for residents, including residents with known risks to their and other residents' safety, were not adequately safeguarded. The provider was required to take urgent action to ensure all residents in the designated centre were appropriately and effectively safeguarded at all times. Assurances regarding the actions taken to ensure residents' safety were received from the provider following the inspection.

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on the actions the provider committed to in their compliance plan to address significant non-compliance with the regulations as identified during a previous inspection carried out in November 2024.This inspection also followed up on both unsolicited and solicited information received in the office of the Chief Inspector of Social Services since the last inspection. Although the provider had progressed some actions as committed to in their compliance plan, significant non-compliances with the regulations were repeated again on this inspection, as set out in both sections of this report.

The registered provider of St Joseph's Care Centre is the Health Service Executive (HSE). The provider is represented by a general service manager. The local management team consisted of a person in charge (PIC) who was appointed by the provider in May 2025 to deputise during unplanned leave of greater than 42 days by the person in charge, an assistant director of nursing (ADON) and clinical nurse managers (CNMs). The local management team were supported by a team of staff nurses, healthcare assistants, activity staff, cleaning, catering and administration staff. A regional manager of older person's services had oversight responsibility for this designated centre and provided support to the centre's local management team. As a national provider involved in operating residential services for older people, this designated centre benefits from access to and support from centralised departments

such as human resources, information technology, practice development, staff training and finance.

The inspectors reviewed the work staff rosters and observed staff practices and were not assured that the skill-mix of staff available ensured adequate supervision and delivery of quality and safe care to residents. While the provider had recruited nursing and healthcare assistant staff since the last inspection, agency staff were contracted to replace a number of nursing and healthcare vacancies. Two clinical nurse manager positions remained vacant. Therefore, this inspection found that the management structure in place did not reflect the centre's statement of purpose. This is a repeated finding from the last inspection, and as a result, the clinical nurse manager was not available to provide clinical support to staff and supervision of care delivery to residents in one unit. This finding was negatively impacting the oversight of residents' safety and quality of life in this unit.

The staff training records showed that staff had access to mandatory and professional development training including in safeguarding residents from abuse, and in responding to and managing residents' responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). However, this training was not reflected in practice by staff who failed to recognise and effectively respond to incidents of residents' responsive behaviours that impacted on residents' dignity, psychological wellbeing and quality of life, and posed safeguarding risks to other residents. Furthermore, staff were not appropriately and effectively supervised in their roles to ensure residents were provided with opportunities to participate in a social activity programme in line with their preferences and capacities. These findings are discussed further under Regulation 16: Training and staff development.

The inspectors found that a number of safeguarding incidents that required notification to the office of the Chief Inspector of Social Services within two working days had not been submitted. These notifications were submitted following the inspection.

Regulation 15: Staffing

The registered provider did not ensure the number and that staff skills were appropriate, having regard to the needs of the residents. This was evidenced by the following findings:

- Adequate numbers of staff with appropriate skills were not available to support the increased needs of residents with complex responsive behaviours, posing a risk that their behaviours may result in a safeguarding incident, and to ensure the safety and comfort of these residents and other residents living in the centre.
- There was an inadequate staff available to ensure continuity of the social activity programme for residents in one unit, as a result, the residents were

seen with little to do, and staff were not allocated to provide social stimulation on the day of the inspection.
- There was an inadequate staff available to adequately support residents who remained in these bedrooms. The inspectors observed that a resident who was visibly distressed and in discomfort was not supported by staff.

This is a repeated finding from the last inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised according to their roles to ensure that they carried out their work to the required standards. This was evidenced by the following findings;

- Staff were not recognising and were not appropriately responding to a number of residents expressing responsive behaviours. In addition, staff practices regarding the monitoring of residents' responsive behaviours were not adequate. For example, records were not consistently completed or regularly reviewed in accordance with the designated centre's policy and the residents' behaviour support care plans.
- Some staff members who spoke with the inspectors were not aware of the safeguarding procedures to follow in response to an allegation of abuse.
- The supervision of cleaning in the centre required improvement, as cleaning chemicals used by household staff for cleaning required a review, as they were not in line with best practice guidance. For example, a chlorine solution without a detergent component was used for routine floor cleaning.

There was ineffective staff allocation planning at unit levels, resulting in the provision of inadequate supervision for residents and staff. This increased the risk to residents across several key areas of service provision in relation to Regulation 5: Individual assessment and care plan, Regulation 6: Health care, Regulation 9: Residents' rights, Regulation 7: Managing behaviour that is challenging and Regulation 8: Protection.

These findings are repeated from the last inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure that there were adequate staffing resources provided, including senior clinical nursing staff, in line with the designated centre's

statement of purpose (SOP).This is a repeated finding from the previous two inspections in May and November 2024. Provision of insufficient staffing resources resulted in the following:

- The management structure was not clearly identified, as the clinical manager was not available in one unit occupied by residents. This arrangement increased the risk that staff were not sure about the reporting structures in the unit.
- In the absence of staff nurse availability, two nursing work shifts consisting of a total of 14hrs were being managed by rostering an additional agency healthcare assistant.
- Baseline staffing was depleted when residents needed a staff escort to go out into the community and to attend healthcare appointments. An example of the impact this arrangement had on residents, as observed by the inspectors, was that the social activity programme scheduled in one unit did not take place on the day of the inspection, as an activity staff member was accompanying a resident on a home visit.
- Two full-time care assistant posts were vacant and were being replaced with agency staff pending completion of recruitment of full-time staff.
- A high number of agency nursing, carer and multi-task attendant staff were being employed each week to cover planned and unplanned leave, which was not a sustainable staffing strategy, and was not in line with the staffing levels the provider committed to provide in the designated centre's statement of purpose.

The oversight of the quality and safety of care and management of risk in the centre was not effective, and as a result, the systems in place to identify, manage and respond to risk and ensure residents' safety were not adequate. This was evidenced by the provider's failure to ensure that;

- all residents were safeguarded from the risk of abuse and to ensure all staff were appropriately identifying, responding to and managing safeguarding risks to residents.
- residents' responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were appropriately managed.
- additional health care professional expertise was provided for residents, as evidenced under Regulation 6: Health care.
- the residents' individual care needs, assessments and care plans were fully effective, this is further detailed under Regulation 5: Individual assessment and care plan.
- there was effective supervision and oversight of staff practices as evidenced under Regulation 16: Training and staff development.
- there was effective oversight of systems in place to ensure incidents were notified to the office of the Chief Inspector of Social Services and were recorded and appropriately investigated with required action.

Under this regulation, the provider was required to submit an urgent compliance plan to address an urgent risk of inadequate staffing resources and the management systems to provide safe and effective care. The provider's response did not provide assurance that the risk was adequately addressed.

Judgment: Not compliant

Regulation 31: Notification of incidents

During the inspection, inspectors identified that after speaking with staff and reviewing the documentation and nursing records, notifiable allegations of safeguarding incidents had occurred; however, the office of the Chief Inspector of Social Services had not received the appropriate notifications. The person in charge submitted the required NF06 notifications retrospectively.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that staff did not consistently provide appropriate support and care for those residents who may display responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). As residents' behaviours were not consistently responded to and appropriately de-escalated and managed by staff, these behaviours posed significant safeguarding risks to other residents. Additionally, the lack of appropriate care for those exhibiting responsive behaviours compromised their dignity and quality of life, as their needs were not met in accordance with best practices and the centre's own policies.

Although the majority of residents' nursing needs were met, actions continued to be necessary to ensure residents' needs were comprehensively assessed and their care plans were sufficiently detailed to guide staff on the care and supports that should be provided for each resident to meet their needs, in line with their individual preferences. During this inspection, it was again noted that the care plans did not include sufficient detail to assist staff in effectively addressing residents' hydration needs, diabetes management, and responsive behaviour challenges. Additionally, not all residents' social care needs were adequately assessed to reflect their personal preferences, leading to social care plans that were inconsistent with their social activity assessments. This is discussed under Regulation 5: Individual assessment and care plan and Regulation 6: Health care. This finding posed a risk

that residents' needs would not be effectively met and communicated to all staff, a concern that was also raised during the last inspection.

Residents had timely access to their general practitioners (GPs), physiotherapy and occupational therapy services. However, inspectors observed that appropriate professional healthcare expertise was not always sought to support residents' psychological welbeing. This is discussed under Regulation 6: Health care.

Although the provider had processes in place to safeguard residents from the risk of abuse, there was not adequate oversight of the implementation of these processes, which did not ensure they were effective. Incidents where other residents' behaviours posed a risk to the safety of others were not adequately investigated or managed. This failure to address these incidents meant that the risks were not effectively mitigated, leaving some residents vulnerable. The provider was required to urgently address this finding on the day of the inspection to assure the Chief Inspector of Social Services that residents were safe in the centre at all times and in accordance with their own policies.

The registered provider ensured that flexible visiting arrangements were in place for residents to meet with their friends and visitors in the centre. Visits were encouraged with precautions in place to manage and mitigate any risk of infection to residents.

Residents had access to local and national newspapers and radios. While televisions were available in the communal sitting rooms, some residents in the multiple occupancy bedrooms shared a television and did not have an individual choice regarding their television viewing and listening.

Regulation 10: Communication difficulties

Residents with communication difficulties were supported to communicate freely, and staff were aware of their needs. Each resident's communication needs were regularly assessed, and a person-centred care plan was developed to guide staff on the supports, including equipment and cues, they needed to communicate effectively.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a number of residents' care documentation, including two residents aged under 65 years, and found actions were necessary to address the following findings:

- There was a disconnect between the assessments of some residents' social care needs and the information in their care plans describing the social activities available to them to meet their interests and capacities. As a result, these residents' social care plans did not describe a social activity programme tailored to meet their individual interests and capacities. Furthermore, many of the care records of the social activities that residents participated in did not reference that residents were provided with opportunities to participate in the social activities described in their care plans.
- Behaviour support care plans developed for residents experiencing responsive behaviours that potentially impacted on other residents' safety and comfort were not sufficiently detailed to guide staff on managing these residents' behaviours. For example, the triggers to two residents' behaviours, although known, were not adequately detailed in their behaviour support care plans. Therefore, guidance was not available for staff to ensure these residents' dignity was preserved by supporting them to prevent the behaviours occurring, and where they occurred, to effectively de-escalate these behaviours.
- A care plan for a resident with an assessed risk of dehydration did not adequately inform staff on the recommended amount of fluids they needed to support with drinking over each 24 hours. This posed a risk that the resident's hydration needs would not be adequately met.
- The care plan for a resident with diabetes and on insulin therapy did not guide staff on the parameters that their blood glucose levels should be maintained within, and the actions staff should take if their blood glucose measurements were outside recommended parameters.

These findings are repeated from the last inspection.

Judgment: Not compliant

Regulation 8: Protection

The provider did not take all reasonable measures to protect residents, as evidenced by the following findings:

- Inspectors found that not all staff were knowledgeable regarding the actions they should take if an allegation or concern of abuse was reported to them or if they observed or suspected abuse to have taken place. The inspectors noted that a number of allegations of abuse and incidents were not recognised and appropriately reported and investigated in the centre.
- Inspectors reviewed actions taken by the person in charge in respect of some allegations. The safeguarding measures put in place by the provider did not provide sufficient assurances that all reasonable precautions had been taken to prevent recurrence. An urgent action was given to the provider in this respect on the day of the inspection.

Under this regulation, the provider was required to submit an urgent compliance plan to address safeguarding issues identified on the day of the inspection. The provider's response did not provide assurance that the risk was adequately addressed.

Judgment: Not compliant

Regulation 9: Residents' rights

Not all residents were provided with adequate opportunities to participate in meaningful and their preferred social activities in line with their interests and capacities. For example:

- The inspectors observed that the scheduled social activities on one unit did not take place, and as a result of the person with responsibility for facilitating residents' social activity programme on the unit not being available, residents did not have any opportunities to participate in the social activities they wished to participate in.
- The inspectors also observed that although a social activity schedule was prepared for each unit, it did not adequately describe some of the social activities taking place for the residents' information and to support them with making personal choices regarding the activities they wished to participate in. For example, a 'contractual programme' was referenced as being available each morning on each of the units, but there was no information on the schedule regarding what this consisted of.
- In addition, from a review of the records maintained regarding each resident's participation and engagement in social activities, the inspectors noted that the records were infrequently completed and did not reference that residents were offered alternative activities when they chose not to participate in the available options.

Residents were not supported to exercise choice in their daily routines. This was evidenced by the following:

- Two residents in the multiple-occupancy bedrooms shared one television. Provision of one television for sharing between two residents did not ensure that each resident had a choice of television viewing and listening.

These findings are repeated from the previous inspection.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The registered provider did not ensure that residents with responsive behaviours that posed a risk of harm to themselves or other residents were responded to and appropriately and adequately managed. On the day of this inspection, the inspectors identified three residents with repeated responsive behaviours that were not being appropriately responded to and managed by staff. One resident's behaviours posed a significant risk to other residents' safety, and staff did not demonstrate up-to-date knowledge and skills regarding their response to and management of this resident's responsive behaviours.

The inspectors also found an example where records were not maintained regarding episodes of responsive behaviours experienced by one resident. This meant that this information was not available and effectively utilised to comprehensively inform residents' individual care and support needs. Furthermore, this information was also not available to manage this behaviour and to guide the development of residents' treatment plans.

Under this regulation, the provider was required to submit an urgent compliance plan to address an urgent risk of in respect of the management of residents with responsive behaviours. The provider's response did not provide assurance that the risk was adequately addressed.

Judgment: Not compliant

Regulation 6: Health care

Nursing practices in relation to residents' assessment and care documentation and management of residents' responsive behaviours did not ensure that residents received a high standard of evidence-based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnaimhseachais. The inspectors' findings are discussed further under Regulation 5: Individual Assessment and Care Plan and Regulation 7: Managing behaviour that is challenging.

Where residents exhibited repetitive responsive behaviours and experienced distress due to their psychological symptoms resulting from living with dementia, these residents were not appropriately referred for additional health care professional expertise to support them with their psychological welbeing.

Judgment: Not compliant

Regulation 11: Visits

Visiting arrangements in the centre were flexible, and practical infection prevention and control precautions were put in place to protect residents from the risk of infection. The inspectors observed that residents could meet with their family and friends, as they wished. Facilities were available to facilitate residents to meet with their visitors in a private area outside of their bedrooms, as they preferred.
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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 6: Health care	Not compliant
Regulation 11: Visits	Compliant

Compliance Plan for St Joseph's Care Centre OSV-0000466

Inspection ID: MON-0045617

Date of inspection: 03/07/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The deployment and planning of staff allocation and roster at unit levels has been reviewed. The planned rosters are confirmed 2 weeks in advance by the CNM in each Unit and approved and signed off by the PIC. Any unplanned leave or shortfall on a daily basis is managed by offering additional shifts from the exisitng HSE staff cohort in the first instance and then regular agency. A maximum of eight residents are accommodated in Our Lady's Unit. A CNM has been deployed to OLU1, effective immediately to provide governance and supervision. There is now CNM supervision in all units within the centre. The management team continue to monitor the usage of agency staff and there has been an ongoing reduction in agency usage since Jan 2025 to date with the appointment of permanent HSE staff. The recruitment of the final three healthcare assistant posts is progressing to the final stage of employment with post accepted by candidates and start date to be agreed. All three candidates are currently working in the Centre as regular agency staff and are familiar with the care need of residents. This will result in all HCA posts being filled in a permanent capacity and further negates the reliance on agency staff. There are 5 WTE CNM posts to support DON/PIC in the governance and management of the Centre in addition to the A/DON. There is a total now of 4.8 WTE staff rostered for the purposes of activation and social engagement programs for residents. The roster for activity staff is now confirmed 2 weeks in and approved by the PIC. This ensures there is three activity staff available to meet the needs of the residents 6 days of the week with 2 staff available on Saturday with deployment arrangements in place to ensure residents in each Unit are activated in line with their assessed needs. All outings and excursion have to be approved now by the PIC. The deployment of social activity staff to ensure residents remaining in the Unit have adequate support and meaningful engagement is monitored through supervision of the CNM. A dedicated CNM is now allocated oversight of activities and is responsible for rosters and approving schedules of activities to include group activities for residents both external and internal.	

Residents who choose to remain in their bedrooms are checked on a routine basis by nursing staff. There is now a CNM rostered in each Unit to ensure staff supervision and adequately support residents in line with their assessed needs.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A CNM has been deployed to the OLU Unit (Our Lady's) to provide governance and ensure staff supervision. This remains in place. There is now a CNM rostered to each unit in the Centre. There is an out of hour's governance structure in place for night duty and at the weekends. A senior staff member is allocated on the roster in charge of each Unit for management purposes and supervision of staff.

A program of training in Positive Behaviour Support which addresses the management of responsive behaviour commenced in 2025. This training is facilitated by an external professional with expertise in training staff in managing and supporting resident with responsive behaviours. To date 88% of staff have completed this training. A further date has been sought to achieve full compliance with training in the management of responsive behaviours.

All staff have undergone on-line safeguarding training in the immediate aftermath of the inspection. Subsequent to this Safeguarding training has been provided to all staff on site in the Centre by a senior social worker on the Adult Safeguarding Team.
Eight sessions of face to face training was delivered over the following dates:
25/07/2025-2 session
28/07/2025-2 sessions
06/08/2025-2 sessions
11/08/2025-2 sessions

One hundred percent of staff involved in direct provision of care have completed refresher safeguarding training.
Person Centred Training will be completed by all nursing and health care staff and staff involved in activities. The training will be provided by an external consultant and focus on topics to include the meaning of person centred care, holistic assessment, promoting choice and independence and the importance of good communication.

The implementation of training in practice will be reviewed as part of the planned supervision policy being developed and introduced within the Centre. There is a daily safety pause and this an opportunity to discuss staff work practice and evidenced based responsive care. The safety pause tool has been revised to capture key quality care metrics in relation to responsive behaviours safeguarding, IPC, staff deployment and other care quality metrics.

There is a CNM rostered in each Unit for supervision to monitor staff work practice. An Organisational Development Intervention is commencing to support CNM's in their supervision practices within the centre and facilitate change in culture of care practice and refocus to a person centred model of care.

A training matrix is maintained to record details of each staff member's training and professional development. The training matrix is updated routinely to ensure oversight and planning for refresher attendance by the PIC.
An annual training needs assessment is conducted to identify and prioritise training needs.

The staff supervision policy is being reviewed to ensure robust procedures are in place for the supervision and management of all staff and work practices according to their roles and responsibilities to ensure a high standard of accountability and professional standards.

The PIC will introduce an observational audit of staff work practices in each Unit to ensure training is being implemented in practice and duties and responsibilities are in line with the operating policies and procedures of the service. Feedback from the audits will be communicated to staff via their team meeting structures to progress changes in cultural and staff work practices and interactions. Quality Improvement Plans will be introduced if required following audit. Audits and QIP's will be monitored.

The Domestic Supervisor has line management responsibility for all household/cleaning staff. Safety data sheets and Health and Safety precautions are in place and approved for use in line with cleaning procedures for all chemicals.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The present interim DON PIC will continue to remain working in the Centre as permanent ADON in the eventual return or permanent filling of the DON/PIC position to ensure continuity of Leadership.

Oversight and supervision of the Centre is ensured also by regular visits of the PPIM (Older Persons Manager) and the Registered Provider (General Manager of Older Person's Service). The PIC will inform and ensure the PPIM has oversight of any reported Safeguarding matters in the shortest reasonable timeframe possible.

The deployment and planning of staff allocation and roster at unit levels has been reviewed. A maximum of eight residents are accommodated in Our Lady's Unit. A CNM has been deployed to OLU1, effective immediately to provide governance and supervision. There is now CNM supervision in all units within the centre.

All staff nurse posts are filled. In the event of any unexpected leave a staff nurse post will only be filled by another staff nurse to ensure staffing levels are in line with the Statement of Purpose of the Centre. Permanent HSE staff are offered additional hours in the first instance and regular agency staff employed only to ensure safe staffing levels are maintained.

Each Unit has a CNM in post to provide governance and supervision. In their absence the most senior nurse on duty is indicated on the roster as the person responsible for the Unit.
CNM 2 cover is provided over the weekends during the daytime shift. During out of hours the most senior nurse on duty is in charge and responsible for reporting to the PIC.
There are 5 WTE CNM posts to support DON/PIC in the governance and management of the Centre in addition to the A/DON. There is a total now of 4.8 WTE staff rostered for the purposes of activation and social engagement programs for residents.
The management team continue to monitor the usage of agency staff and there has been an ongoing reduction in agency usage since Jan 2025 to date.

The recruitment of the final three healthcare assistant posts is being completed. All three staff are awaiting HSE start dates and are working already in the centre in a permanent capacity from the Agency until start dates are confirmed, Garda vetting is pending and once received HSE appointment will be completed. This will result in all HCA posts being filled in a permanent capacity.

The roster for activity staff is now planned two weeks in advance and approved by the PIC. All outings and excursion have to be approved by the PIC. The deployment of activity staff is managed to ensure when outings are taking place residents who remain in the Centre continue to have access to and are supported in activities of their choice by remaining activity staff.

Workshops will be facilitated by a HSE expert in organisational change and development. The purpose of the Workshops will be to support cultural change and promote best practice within the care environment in line with the training being provided to staff on Person Centred Care to ensure it will be implemented by all staff.
The staff supervision policy is being reviewed to ensure robust procedures are in place for the supervision and management of all staff and work practices undertaken according.

The reporting responsibilities of all staff and the Designated Officer role are being reinforced via the developed briefing template on Safeguarding and the framework for reporting.

Safeguarding training has been provided to all staff on site in the Centre by a senior social worker on the Adult Safeguarding Team. Safeguarding has been added as a recurring topic on all meeting agendas to include governance, safety and resident forum.

The responsive behavior support care plans for each of the three residents have been reviewed in addition to care plans for any other residents who exhibit behaviors to ensure they are sufficiently detailed to guide staff.

Where a change in behaviour is observed residents are reviewed by their GP and referrals made for specialist input to their care. There is an increase of HCA hours to provide additional supervision in communal areas to support residents with behaviours. All residents with responsive behaviours are referred to the Psychiatry of Later Life (PoLL) team for further assessment and review of behaviours and medication requirements. There is ongoing liaison with the PoLL, Community Mental Health Nurse and unit Nursing Team. All recommendations by the PoLL team are implemented.
The CNM's continue to audit care plans in each Unit to ensure they meet the assessed needs of all residents.

The care plan audits results are analysed in relation to the risk of dehydration, responsive behaviours and glucose measurements. The feedback from care plan audits results will be discussed at each staff meeting and individually with each nominated nurse responsible for care plan reviews. Corrective actions will be monitored by the PIC to ensure they are implemented.

The risk advisor has completed onsite training to staff in relation to the National Incident report Form and Incident Management Framework and the obligation to report at the point occurrence any incident or Safeguarding concern or suspicion of abuse.

The PIC will introduce an observational audit of staff work practices in each Unit to ensure training is being implemented in practice and duties and responsibilities are in line with the operating policies and procedures
The safety pause tool has been revised to capture key quality care metrics in relation to responsive behaviours safeguarding, IPC, staff deployment and other care quality metrics and to ensure an increased opportunity for reporting to the PIC to ensure matters are reported at the point of occurrence and statutory notifications obligations are met.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All identified statutory safeguarding incidents once brought to the attention of the PIC have been reported retrospectively.

A new briefing template and flowchart is in place to summarise the Safeguarding Process and the role of the Designated Officer including contact details. This has been disseminated to each unit/area for presentation and display to all staff in that area.

The reporting responsibilities of all staff and the Designated Officer role are being reinforced by the presentation and discussion of the briefing template on the key responsibilities of all staff within the Safeguarding Procedures and through the onsite Safeguarding training completed.

The risk advisor has completed onsite training to staff in relation to the National Incident report Form and Incident Management Framework and the obligation to report at the point occurrence any incident or Safeguarding concern or suspicion of abuse.

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:
A further review of the social care assessments will be completed to ensure social activity care plans are in line with the described interest and capacity of each resident. The documenting of records of residents participation and engagement in their preferred activities will be reviewed to ensure they are maintained up to date and describe in detail their level of engagement on a daily basis. The CNM's will complete audits of the records by activity staff. The clinical facilitator is providing guidance to staff on reviewing social activity care plans in line with the will and preference of each resident to ensure they are suitable to their capacity and life stage.

Four activity staff have completed training during 2025 through Age and Opportunity Organisation to ensure they are skilled appropriately to meet the activation needs of residents.

A review of behavior support plans for all residents will be completed to ensure they are sufficiently detailed to guide staff on all known triggers and de-escalation techniques. All ABC charts are subject now to weekly review by the CNM on each Unit and responsive behavior care plans are updated based on the outcome of the ABC reviews.

Care plans will be reviewed and updated to ensure adequate fluid intake is outlined within the care plans for those with an identified risk of dehydration.
The care plans for all residents on insulin therapy have been reviewed to ensure the parameters that their blood glucose levels should be maintained within are documeted and care plans include guidance on the action to be taken when observed to be outside normal parameters.

The CNM's continue to audit care plans in each Unit to ensure they meet the assessed needs of all residents. The care plan audit criteria will be reviewed to incude risks in relation to dehydration, responsive behaviours and glucose measurements.
The feedback from care plan audits are discussed at each staff meeting and individually with each assigned key worker responsible for care plan reviews.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The management team in the Centre have instructed all staff across the service to recomplete the HSE National Policy and Procedures on Safeguarding Vulnerable Person's at Risk of Abuse online course in the immediate aftermath of the inspection by all staff.

In addition Safeguarding training has been provided to all staff on site in the Centre by a senior social worker on the Adult Safeguarding Team.

Each safeguarding concern reported has been referred to the Safeguarding Team. Safeguarding plans have been developed and reviewed with the Safeguarding Social

Worker. All concerns reported have been fully investigated in line with HSE Safeguarding Policy and agreed required actions implemented in line with the direction of the Safeguarding Team and the policy of the Centre.

There are two Designated Officers in the Centre whose roles in the Safeguarding Process are;
Receiving concerns or allegations of abuse regarding vulnerable persons.
Ensuring reporting obligations are met. Conducting preliminary assessments and further investigations under the direction of the PIC. A Designated Officer is contactable out of hours.

A new briefing template and flowchart has been implemented to summarise the Safeguarding Process and the role of the Designated Officer including contact details. This has been disseminated to each unit/area for presentation and display to all staff.

The reporting responsibilities of all staff and the Designated Officer role are being reinforced via the developed briefing template on Safeguarding and the framework for reporting.

The briefing template on key actions in the Safeguarding procedures is displayed across all Units in the Centre. Safeguarding has been added as a recurring topic on all meeting agendas to include governance, safety, resident forum, CNM Unit team meetings and during daily handover and safety pause. All staff grades on duty in each unit attend the safety pause.

A Serious Incident Management Team (SIMT) review of all the notified Safeguarding concerns has been completed on an individual basis for each concern notified. The review was completed by an interdisciplinary Team to include, the Principal Social Worker from the Safeguarding Protection Team, General Manager, PPIM, the HSE Risk Advisor and PIC. The purpose of this review was be to identify lesson for learning, seek assurance and implementation of robust safeguarding action for all residents.
A weekly report is forwarded to the registered provider in respect of safeguarding incidents. Reviews now take place with the QPS advisor, compliance officer, PPIM and Registered Provider in respect of same.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
There is now a WTE of 4.8 staff rostered for the purposes of activation and social engagement programs for residents. The roster for activity staff is now planned two weeks in advance and approved by the PIC.
All outings and excursion have to be approved now by the PIC. The deployment of social activity staff to ensure residents remaining in the Unit have adequate support and meaningful engagement is monitored through supervision of the CNM.
The activity schedule will be reviewed to ensure it is detailed with information to describe the choice and type of activities being planned daily to include details for those who do not wish to partake in group activities. There are three activity staff available to meet the

needs of the residents six days of the week with two staff available on Saturday. Activity staff will be deployed to ensure group and individual one to one activities are facilitated throughout each day across all Units in the Centre. Nursing admin approve the schedule of activities and roster for the Centre.
The documenting of records of residents participation and engagement in their preferred activities will be reviewed to ensure they are maintained up to date and describe in detail their level of engagement on a daily basis. The CNM will complete audits of the records by activity staff.

TV's were purchased and installed in bedroom where each resident did not have their own TV. All bedrooms have been rechecked post inspection and a TV is insitu in each bedroom and each resident had their own TV in shared bedrooms on the day of inspection.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The responsive behavior support care plans for each of the three residents have been reviewed in addition to care plans for any other residents who exhibit behaviors to ensure they are sufficiently detailed to guide staff on all known triggers and de-escalation techniques.

Individual actions to support and promote best practice have been taken. One resident has their own bedroom and is no longer sharing. Another resident in agreement with their nominated representative has being relocated to a smaller Unit to ensure the care environment is better suited to their needs.

A program of training in Positive Behaviour Support which addresses the management of responsive behaviour commenced in 2025 and is continuing across the service to ensure attendance by all staff. This training is facilitated by an external professional with expertise in training staff in managing and supporting resident with responsive behaviours.

The completion of ABC charts will be monitored and supervised by the CNM on each Unit to ensure all episodes of responsive behaviour are documented to identify any possible causative factors and allow review for trends and further development and review of behaviour support plans. The ABC charts are reviewed weekly by the CNM in each Unit now and care plans for behaviours updated based on the outcome of the reviews reported to the PIC.

Where a change in behaviour is observed residents are reviewed by their GP and referrals made for specialist input to their care on the guidance of the GP.

There is an increase of HCA hours to provide additional supervision in communal areas to support residents with behaviours.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All residents that exhibit responsive behaviours have positive support care plans in place which outline any triggers to behaviour, measures to be taken to reduce behaviour and activities to offer in line with the residents will and preference.
Each episode of responsive behaviour is recorded on ABC chart. This is a person-cantered approach used to improve care planning by analysing events to identify underlying causes and inform measures to be taken for prevention and management of responsive behaviour. Analysis of ABC chart is conducted weekly and where new triggers are identified the care plan is reviewed and amended to include these and the implementations required to resolve the behaviour. Where no trigger is identified care plans are reviewed at least every 4 months and according to changes in residents' condition.
The residents presenting behaviour is also measured against the PINCHME tool to determine if exacerbation of responsive behaviour is due to any physical or medical trigger (delirium) which may be resolved following intervention from G.P.
All residents with responsive behaviours are referred to the Psychiatry of Later Life (PoLL) team for further assessment and review of behaviours and medication requirements. There is ongoing liaison with the PoLL, Community Mental Health Nurse and unit Nursing Team. All recommendations by the PoLL team are implemented.
Multi-disciplinary Team meetings are undertaken where an overall review of their health condition, medication and supportive equipment needs are reviewed. All residents exhibiting responsive behaviours are referred to psychiatric services for specialist input and guidance based on consultation and in line with their GP reviews and medical input.
Multidisciplinary team meetings continue fortnightly throughout the year where an overall assessment/review of residents' health condition, medication and supportive needs are discussed and addressed. This includes any equipment required to improve residents' quality of life or access to community services.
All resident's care plans and clinical risk assessment are reviewed at a minimum of four monthly intervals and sooner where if required based on a change in their health status or identification of new care need.
The CNM's continue to audit care plans in each Unit to ensure they meet the assessed needs of all residents. The care plan audit is conducted to ensure nursing practice assessment and care planning is meeting the needs of residents with responsive behaviours.

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.	Not Compliant	Orange	31/08/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2025
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	Red	31/08/2025

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.	Not Compliant	Orange	31/08/2025
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Not Compliant	Red	14/07/2025
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	07/07/2025
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	30/09/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an	Not Compliant	Orange	30/09/2025

	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.			
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	30/08/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/09/2025
Regulation 6(2)(c)	The person in charge shall, in so	Not Compliant	Orange	30/09/2025

	far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	15/07/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	30/08/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	15/08/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	25/08/2025

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	03/07/2025