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:	Hollybrook Lodge
Name of provider:	St. James's Hospital
Address of centre:	St Michael's Estate, Bulfin Road, Inchicore, Dublin 8
Type of inspection:	Announced
Date of inspection:	05 June 2025
Centre ID:	OSV-0005053
Fieldwork ID:	MON-0044688

About the designated centre

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

Hollybrook Lodge provides residential care to 48 residents. All residents and patients cared for in Hollybrook Lodge have access to specialist medical and nursing care, a wide range of support therapies including Physiotherapy, Clinical Nutrition, Medical Social Work, Speech & Language therapy and specialist aged-care services & treatments including Old Age Psychiatry, Bone Health, and Memory Clinic. Hollybrook is a secure, bright, purpose built two storey structure with stairs and a lift. There are two units, Robinson Unit on the ground floor, and the McAleese unit on the first floor. Each unit provides accommodation for 24 residents. There is an enclosed garden for resident's use adjacent to and behind the building. The family room is located on the first floor and there is an external designated smoking area for residents. The Hollybrook Lodge Residential Care Centre is managed by the Medicine for the Elderly Directorate of St James Hospital. The scope of the directorate services comprises acute in-patient, rehabilitation, out-patient, day care, transitional care, residential care and community outreach.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 5 June 2025	08:00hrs to 17:15hrs	Niamh Moore	Lead
Thursday 5 June 2025	08:00hrs to 17:15hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

The inspectors spent time in the centre observing the environment and the care provided, and talking to residents, visitors and staff to see what life was like for residents living in Hollybrook Lodge. Inspectors met with and spoke with nine residents and three visitors during the day. Overall, residents and visitors both gave positive feedback about communication, the kindness of staff and the cleanliness of the centre.

Hollybrook Lodge is located in Inchicore, Dublin 8. The centre is registered for 48 residents and there was 48 residents living in the centre on the day of the inspection. The building comprises two storeys with two units referred to as Mary Robinson, located on the ground floor and Mary McAleese, located on the first floor. Both floors of the centre were accessible by stairs and a lift. Additional communal space was available on the ground and first floor such as an oratory, a multi-purpose room and a family room. Residents' accommodation was located within the individual units in addition to a combined day and dining room. Inspectors found that while there were pieces of furniture in the communal rooms to make these spaces more homely, the storage of clinical items such as waste bins, in this area took away from the homely feel.

There was access to the garden from the ground floor residential unit and from the activity room, which residents could freely enter. One of these areas also located the designated smoking area for residents. Inspectors observed that this smoking area space was limited and when there were three residents and one staff present, not all were able to be sheltered within the space. Inspectors also reviewed meeting minutes where residents requested for this smoking area to be made bigger. Residents from the first floor unit were seen to freely mobilise around their unit with staff allocated to specific residents to take them outside frequently when they requested to go outside.

Resident's accommodation comprised of 34 single rooms, four twin-bedded rooms and two three-bedded rooms, all with en-suite facilities. Resident's bedrooms had personalised identifiers such as pictures of musical instruments or specific football clubs on their doors to assist them locating their rooms. Inspectors viewed some bedrooms and saw that residents were supported to personalise their bedrooms, with items such as photographs, artwork, bed linen, and personal belongings. Bedrooms were seen to be clean and two visitors spoken with complimented the cleanliness of the bedrooms. However, inspectors found that there was insufficient privacy arrangements in some of the bedrooms on the first floor which will be further discussed within this report.

Notice boards on the individual units displayed pictures of residents participating in activities and residents art work. There was also information available to residents such as on safeguarding, falls prevention and the activity schedule. A new initiative was in place to gather residents' feedback on television programme suggestions with

whiteboards recording this data seen in communal areas. Inspectors observed that there were "shower schedules" on display at these noticeboards, which outlined residents were assigned a shower day each week. This raised a concern of institutional practices, however staff and residents spoken with confirmed that residents could ask for a shower on any day and this would be provided. Activities were seen to occur on the day of the inspection such as exercise in the morning and musical entertainment occurred in the afternoon. Inspectors observed that residents were singing and celebrating one resident's birthday with a birthday cake and balloons. Outside of group activities some residents were seen to spend time in the communal areas completing some art work, telling the inspectors that they liked to spend their day doing activities.

Inspectors reviewed the questionnaires completed by residents or their family members as part of this announced inspection. A total of eight questionnaires were completed. Overall feedback on the service was very positive, reporting to feel content living in the centre and were treated with respect and kindness by staff. One resident reported they were very happy living in the centre, and two families reported to sleep well knowing their family member was under the care of lovely and professional staff. However, one resident said that the food and the dining room could be better. Feedback that inspectors received during the inspection was varied, many residents gave compliments on the environment and kindness of staff and some residents said that while they were happy in the centre, it was not home. Two persons spoken with did state that at times they had to wait for assistance due to staffing levels.

The inspectors saw that residents were in the dining room, sitting at tables which were set for the lunch-time service thirty minutes prior to their lunch being served to them. Some residents told the inspectors that this was usual routine for them and a staff member told the inspectors that this was residents' choice to remain in the area after the exercise session which had concluded. Inspectors observed the lunchtime service and found there was a calm environment with sufficient staff available to provide assistance to residents in a timely manner. There was a choice of main meal on the day of beef or salmon, in addition, other food requests for residents were also seen to have been accommodated. Three residents said that they did not like the beef dish on the day, reporting it was very tough. Inspectors noted that many dishes with the beef option were not eaten. Some residents chose to eat in their bedrooms and told the inspectors that this was their choice with one resident saying they like being on their own and not in the big rooms with everyone.

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 provided.

Capacity and capability

This was an announced inspection carried out to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulation 2013 (as amended). On this inspection, the inspectors also followed up on the compliance plan submitted by the registered provider following the previous inspection in June 2024 and information, both solicited and unsolicited, received since then. The inspectors found that action had not been taken to fully address the findings of the previous inspection from June 2024, in addition some aspects of the concerns raised through unsolicited information were substantiated, and further discussed under the relevant regulations.

The registered provider of Hollybrook Lodge is St James's Hospital. The person appointed by the registered provider with designated responsibility was the Chief Executive Officer of the hospital. The management structure also included two senior management from the hospital. All three of these personnel were present during this inspection. The local management structure included the person in charge, two clinical nurse managers grade II and two clinical nurse managers grade I.

While there were some policies and procedures in place, the policies reviewed by the inspectors on the day were not specific to the service, and some had not been adopted and implemented by staff. This is further discussed under Regulation 4: Written policies and procedures.

There was an ongoing training programme in the centre. The training matrix reviewed by the inspectors recorded high levels of attendance at mandatory training such as safeguarding, manual handling, infection control and basic life saving, in addition to medicine management for staff nurses.

Nothwithstanding the improvements made to the directory of residents the registered provider had not ensured that maintenance of this directory was in line with the regulations.

There was an annual review of the quality and safety of care delivered to residents completed against relevant standards and which evidenced consultation with residents for the period of May 2024 to May 2025. A quality improvement plan was also devised to include improvements to the laundry service, outings and more garden access.

Information related to the designated centre was captured through nursing metrics, meetings and audits. Inspectors saw that oversight by the registered provider was through these forums such as in person audits by senior management and the Quality department. However, inspectors found that some of the systems in place to monitor, identify and sustain improvement were not fully effective and is discussed further in this report under Regulation 23: Governance and Management.

There was a complaints policy in place in the centre which residents were made aware of on admission and this was displayed around the centre. However, inspectors reviewed a number of complaints and found that the registered provider

had not ensured that the steps set out in the regulations on the complaints process were taken. This is further discussed under Regulation 34: Complaints procedures.

Regulation 16: Training and staff development

Staff were supported and facilitated to receive mandatory and relevant training for their roles.

Judgment: Compliant

Regulation 19: Directory of residents

Following the last inspection, the registered provider had ensured that there was one directory of residents within the centre. However, inspectors found that this referenced information from 2025 and did not contain information on previous residents as was required by the regulations. In addition, not all information specified in Schedule 3 was included. For example, the cause of death was not included for residents who had died at the designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that the oversight systems in place required strengthening to ensure all areas of the service were safe, appropriate, consistent and effectively managed. For example:

- Internal management systems did not identify the findings of this inspection for example:
    - Fire precautions were not in line with regulation.
    - A recent audit dated 23 May 2025 found that the contracts of care and care planning arrangements met the requirements of the regulations, this did not align with the inspection findings where repeat findings were seen, and discussed further under Regulation 24: Contract for the provision of services and Regulation 5: Individual assessment and care plan.
    - While a review of a peer-to-peer safeguarding incident was completed, this review did not identify that a control measure of one-to-one staffing was not in place at the time of the incident.

- Information governance required improvement. There was conflicting information relating to visiting procedures within the centre within the visiting policy and residents' contracts for the provision of services.
- The registered provider had not fully addressed their compliance plan from the inspection in June 2024 and therefore repeat inspection findings were found. This particularly related to:
  - Policies were not in place or specific to the designated centre which is a repeat finding from previous inspection.
  - The directory of residents was not in line with the regulations.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of three resident's contracts for care were reviewed by the inspectors. These contracts did not set out the terms required in the regulations. For example:

- Two contracts did not include the details of the bedroom to be provided to the resident.
- Two of the contracts did not include the details regarding the number of occupants of the bedroom on which the resident shall reside in the centre.
- One contract was not agreed with or signed by the resident or their nominated person on admission. The resident was admitted to the centre on 19 May 2025.

This is a repeat finding from the previous inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had not ensured that the management of complaints were in line with the requirements of the regulations. For example:

- While the majority of the six complaints reviewed by the inspectors were actioned, there was no copy of the written response informing the complainant whether or not their complaint had been upheld, the reasons for the decision and any improvements recommended.
- The complaints officer, nominated in July 2024, had not received suitable training to deal with complaints in accordance with the designated centres complaints procedure.
- The complaints were not fully recorded. For example, the outcomes of reviews did not contain appropriate information.

- There was no general report provided on the level of engagement of independent advocacy services with residents, complaints received, including reviews conducted as required as part of the annual review.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All policies set out in Schedule 5 were not prepared in writing, adopted and implemented in practice. For example:

- Some policies reviewed by the inspectors were not centre specific. For example, the risk management policy and fire policy referred to an acute setting and not the specific practices in place for the designated centre.
- Not all policies set out in Schedule 5 of the regulations were available for staff. There was no policy provided to the inspectors on the following:
    - Temporary absence and discharge of residents
    - The ordering, receipt, prescribing, storing and administration of medicines to residents
    - The handling and disposal of unused or out of date medicines
    - Infection prevention and control procedures.
- Inspectors saw evidence that the fire policy had not been implemented. This will be further discussed under Regulation 28: Fire precautions.

This is a repeat finding from the previous inspection.

Judgment: Not compliant

Quality and safety

Inspectors found that the majority of residents living in Hollybrook Lodge received a good standard of care and support to ensure that they could enjoy a good quality of life. Further improvements were required in respect of care planning, restraints, residents' rights, the premises and fire safety to further enhance the quality of care provided to the residents.

Inspectors reviewed a sample of residents' care documentation. Inspectors saw that improvements were seen with person-centred care plans. Residents' needs were in general comprehensively assessed using validated assessment tools and care plans were reviewed at regular intervals in line with the timeframes outlined within the regulations. Notwithstanding the overall improvements seen, further oversight was

required to ensure that residents were receiving care based on their assessments and care plans.

A general practitioner (GP) visited the centre Monday to Friday each week. There was on call GP services referred to outside of these hours. Residents' records showed that residents had access to services such as psychiatry of later life, speech and language therapy, dietitians and physiotherapy. Records showed that recommendations from these professionals were recorded in the residents care plan and followed by staff.

Staff had access to relevant training on human rights, restraints and responsive behaviours. The registered provider had recently reviewed their policy on the use of restraint effective from May 2025. However, inspectors found this policy had not been fully implemented in three out of five records reviewed. This is further discussed under Regulation 7: Managing behaviour that is challenging.

Residents were supported to exercise their civil, political and religious rights. There was a varied activity programme available for residents to attend. Overall, residents' rights were upheld within the centre, however residents' rights to privacy required further review.

There was suitable communal spaces available to support residents to receive visitors. Residents and visitors told the inspectors there were no restrictions on visiting reporting they can "come and go as they like". However, information relating to visiting times were not aligned in all documents.

While the premises was found to be clean and inspectors observed efforts to create a homely environment, further review and oversight of the premises was required as outlined under Regulation 17: Premises.

Staff were trained annually in fire safety and daily fire safety checks were completed. However,further oversight was required to ensure that adequate fire safety precautions were in place, which are discussed under Regulation 28: Fire precautions.

Regulation 11: Visits

There was a written visitors policy which outlined the visitors access to the centre.

Judgment: Compliant

Regulation 17: Premises

Some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows:

- The family room on the first floor did not have a call bell available in the event of an emergency.
- Doors were blocked due to the placement of bins in the staff room on the 1st floor and in the kitchen in the McAleese unit.
- Uncovered general waste and recycling bins were placed beside an armchair in the residents communal living room in the McAleese unit
- Inappropriate storage of equipment was seen in various parts of the centre. For example; a filing cabinet containing items used by kitchen staff was stored in the communal living room in the McAleese unit, bins to collect plastic bottles were also stored in the residents communal living room on this unit, a ladder was stored in the communications room on the ground floor. Storage of items on the floor prevented effective cleaning.This is a repeat finding from the previous inspection.
- There was no signage to indicate the storage of oxygen in the oratory or the clinic room in both of the residential units.
- Vents in the staff room on the first floor were covered in duct tape.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control training was up to-date. Staff spoken with had good knowledge on infection control practices. There was sufficient resources for housekeeping on the day of the inspection, and the centre was clean. The limitations to infection control precautions such as inappropriate storage is discussed under Regulation 17: Premises, and the gaps in a centre specific cleaning policy is outlined under Regulation 4: Written policies and procedures.

Judgment: Compliant

Regulation 28: Fire precautions

Inspectors found that the management of fire safety measures within the designated centre required further oversight.

- The registered provider did not ensure that by means of fire drills at suitable intervals persons working in the designated centre were aware of the procedure to be followed in case of a fire. For example:
    - Fire drills were not documented or carried out at regular intervals as outlined in the centres fire policy. The drills reviewed on the day of the

inspection did not provide assurances that they were reflective of all possible high-risk scenarios to include compartments and lower staffing levels such as at night time.
    - Simulated evacuations had not been undertaken, outside of those led by an external facilitator, to be assured that staff were fully aware of the actions to be taken, if a fire occurred, when the trainer was not present in the building.
- The registered provider did not take adequate arrangements for containing fire. For example; doors to the kitchen and stairs on the ground floor had visibly large gaps which did not assure they would adequately contain smoke in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Not all care reviewed on the day of inspection, reflected the assessed health, personal or social care needs of the resident. For example:

- A resident with an additional specific role of staff in place did not have an assessment of need for this in place.
- Some care plans referred to infection control measures for Covid-19 which were not relevant to the individual resident.
- A resident's continence assessment did not match the supplies within their bedroom.
- A smoking risk assessment was generic and did not identify the resident's assessed needs.
- For known safeguarding needs, safeguarding care plans were generic and did not detail specific measures in place to safeguard the individual residents.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors found that residents had access to appropriate medical and allied health and social care professional support to meet their needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Restraint use was not in line with the *National Policy Towards a Restraint Free Environment in Nursing Homes*, for example:

- There was no documented evidence of alternatives trailed to ensure the least restrictive measure was in place for one resident with a bed rail.
- One resident who had a sensor alarm did not have an assessment or care plan in place to ensure this restrictive practice was used in line with the residents' current assessed needs and for the least time required.
- One resident who had restrictive measures in place due to a risk of absconsion did not have a risk assessment completed or alternatives trialled to ensure the least restrictive measure was in place. As a result it was unclear the reason for the use of restrictive measures for this resident.

Judgment: Substantially compliant

Regulation 8: Protection

There were arrangements in place to safeguard residents from abuse. Staff had received training in the safeguarding of vulnerable adults. The registered provider was in the process of reviewing their safeguarding policy. Inspectors were aware that there was an ongoing safeguarding investigation which had been referred to the appropriate external agencies, for example the safeguarding and protection team. However, findings relating to residents' safeguarding care plans is reflected under Regulation 5: Individual assessment and care plan.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had not ensured that all residents in the centre had their privacy and dignity upheld. This particularly related to some bedrooms on the first floor where the view into some of these bedrooms from surrounding buildings was very clear. While there were roller blinds and curtains available, these measures were not sufficient during daylight hours to ensure the privacy and dignity of these residents was maintained.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Hollybrook Lodge OSV-0005053

Inspection ID: MON-0044688

Date of inspection: 05/06/2025

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of Residents is now fully complete. In order to maintain compliance, the following actions will be undertaken: • Update Hollybrook Lodge's Operational policy to confirm the procedure and assigned responsibility for completion and maintenance of the Centre's Directory of Residents • Improve the process and tools used for auditing the Directory of Residents • Add audit findings and improvement plan to the quarterly Quality Assurance and Improvement Committee meeting agenda.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The governance oversight of safety, quality and continuous improvement at Hollybrook Lodge is and will continue to be strengthened through the following actions: • Implement the outstanding actions from the Centre's 2024 Compliance Plan • Develop an improved audit programme covering all key areas (e.g. Directory of Residents, Contracts, Complaints, Care Plans) that will inform the Centre's Quality Improvement Plan. • Plan and implement the development and audit of all required Schedule 5 PPPGs.	

• Include PPPG development, audit outcomes and related improvements in the quarterly Quality Assurance and Improvement Committee meeting agenda.

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services: In order to meet and maintain compliance the following actions will be undertaken: • Update and implement a revised contract template to meet all Regulation 24 requirements. • Update operational policy to assign clear responsibility for contract completion and maintenance. • Improve contract of care's audit process and tools. • Include contract of care's audit findings in the quarterly Quality Assurance and Improvement Committee meeting agenda.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: In order to meet and maintain compliance, the following actions have and / or will be undertaken: • Hollybrook Lodge's nominated Complaints Officer i.e. the PIC, has completed the Complaints Management training provided by SJH Patient Experience (Complaints) Office. The PIC is scheduled to attend accredited HSE Complaints' training in 2025. • Update and implement a revised Complaint Log and Outcome Report template to capture all the requirements of Regulation 34 as outlined in the Centre's complaint Policy • Improve the process and tools used for auditing Complaints Management • Add complaints audit findings and improvement plan i.e., the Centre's Quality Improvement Plan, as a standing item on the Centre's quarterly Quality Assurance and Improvement Committee meeting agenda

• Generate a summary report of complaints and advocacy engagement for inclusion in the Centre's Annual Review Report.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
In order to meet and maintain compliance, the following actions will be undertaken:

• Plan and implement a schedule for the development, implementation and assurance (audit) of all required PPPGs i.e., Schedule 5.

• Add PPPG development (including assurance) as a standing item on the Centre's quarterly Quality Assurance and Improvement Committee meeting agenda

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to meet and maintain compliance, the following actions have and / or will be undertaken:

• A call bell has been installed in the first-floor family room.
• Obstructions and inappropriate storage in staff areas and communal rooms have been removed or relocated.
• Uncovered general waste and recycling bins and filing cabinet have been removed and replaced with appropriate bins in the residents communal living room.
• Monthly environment audits now include to audit staff rooms and comms room.
Corrective actions and/ or improvements identified through audit will be added to the Centre's Quality Improvement Plan and tabled for review at the Centre's Quality Assurance and Improvement Committee meeting.
• Oxygen signage erected; vents in staff room scheduled for replacement.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: In order to meet and maintain compliance, the following actions will be undertaken: • Fire Drill arrangements have been reviewed to ensure the following: • A minimum of two announced Fire Drills including simulated evacuation will be undertaken every quarter. This will be rotated at different hours to cover day and night and periods of lower staffing levels. First unannounced drill undertaken on 18.07.2025. • Observations and learning from Fire Drills will be documented and used to inform improvement and staff learning • Drill learnings will inform training and improvement actions. • Fire containment issues identified (e.g., door gaps) are scheduled for immediate action by specialist contractor. • Fire doors to be serviced bi-monthly by specialist fire safety provider.	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: • All the assessments and care plan for existing Residents have been reviewed to ensure they are complete and accurate i.e., all assessed risks have a corresponding complete and current care plan in place. In order to meet and maintain compliance, the following actions will be undertaken: • Review and update the Centre's Admission and Care Plan Policy to ensure staff are aware of their responsibilities for assuring that care plans are always complete and accurate • Improve the process and tools used for auditing Individual Assessment and Care Planning • Add the findings and improvements from the Individual Assessment and Care Planning audit as a standing review item on the Centre's quarterly Quality Assurance and Improvement Committee meeting agenda • Resident care plans will be reviewed to ensure they reflect current and accurate assessments. • A revised care planning audit tool will be implemented to support quarterly review compliance. • Care plan audit findings will be tabled for review at the Centre's Quality Assurance and Improvement Committee meeting	

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
In order to meet and maintain compliance, the following actions will be undertaken:

• Complete the development of the Centre's Restraint and Restrictive Practices policy and communicate the assigned responsibilities and procedures to all staff.

• Add restraint / restrictive practices to the list of alerts included in the Centre's daily safety huddles and staff handovers.

• Improve the process and tools used for auditing Restraint / Restrictive Practice

• Add the findings and improvements from the Restraint / Restrictive Practice audit as a standing review item on the Centre's quarterly Quality Assurance and Improvement Committee meeting agenda

• All restrictive practices will be reviewed and documented in accordance with national restraint policy.
• Ongoing refresher training on least restrictive practice will be provided to all staff.
• Daily huddles and handover now include residents with behavioural support needs to promote shared understanding and awareness.
• A restraint register will be maintained and audited regularly. All audit outcomes and associated action plans will be shared in operational meetings and Quality Assurance and Improvement Committee meetings.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2025
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Substantially Compliant	Yellow	31/10/2025
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	31/10/2025
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	31/10/2025
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to	Not Compliant	Orange	31/10/2025

	the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	15/08/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/08/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant	Substantially Compliant	Yellow	31/10/2025

	whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/10/2025
Regulation 34(6)(b)(i)	The registered provider shall ensure that as part of the designated centre's annual review, as referred to in Part 7, a general report is provided on the level of engagement of independent advocacy services with residents.	Substantially Compliant	Yellow	31/10/2025
Regulation 34(6)(b)(ii)	The registered provider shall ensure that as part of the designated	Substantially Compliant	Yellow	31/10/2025

	centre's annual review, as referred to in Part 7, a general report is provided on complaints received, including reviews conducted.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Not Compliant	Orange	31/10/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	31/12/2025
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	31/12/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/09/2025

Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/09/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/09/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/10/2025