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:	Kilminchy Lodge Nursing Home
Name of provider:	Kilminchy Lodge Nursing Home Limited
Address of centre:	Kilminchy, Portlaoise, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	22 July 2025
Centre ID:	OSV-0000052
Fieldwork ID:	MON-0047408

About the designated centre

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

This is a single-storey purpose built centre. Kilminchy Lodge Nursing Home is staffed by qualified nursing and care staff at all times and caters for residents whose dependency levels range from low to maximum. It accommodates both female and male residents over the age of 18 years with a varied range of care needs. This centre can accommodate up to 74 residents. It has 68 single bedrooms, and three twin-bedrooms, all with en suite facilities. Privacy screening is provided in the shared bedrooms. There is a large living room where many of the daily activities take place. The main kitchen is adjacent to the large dining area which leads to a secure outdoor area. The centre is situated in residential area in a busy town and is serviced by nearby restaurants/pubs/libraries/ pharmacies/ GP surgeries etc.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	67

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
Tuesday 22 July 2025	08:30hrs to 18:30hrs	Laurena Guinan	Lead
Tuesday 22 July 2025	08:30hrs to 18:30hrs	Niamh Moore	Support

What residents told us and what inspectors observed

Residents living in Kilminchy Lodge told inspectors that it was a lovely place to live, with one resident saying that the staff were 'some of the kindest people I ever met'. While it was clear that staff strived to deliver high quality, rights-based care, inspectors saw evidence that a weakened management structure did not support safe, consistent delivery of care. After an introductory meeting with the Regional Manager and an Assistant Director of Nursing (ADON), the inspectors walked around the centre. The nursing home is a single storey building separated into three units, Slieve Bloom, Dunamaise, and Maryborough. There was a reception area at the main entrance which had information such as fire evacuation, safeguarding, and the complaints policy on display. A large living room was to the right, and this had direct access to a toilet for residents using this space. The window to this toilet was open, with the restrictor removed. This could pose a risk of absconsion as the window opened onto the unsecured front car park, and the risk of a resident using the toilet unaccompanied being clearly visible to people in the car park. The ADON was informed, who immediately secured the window, and reported that the room had just been cleaned. Inspectors also informed the ADON that there was no call bell in the toilet area should a resident need to call for assistance.

The reception area also gave access to a large dining area which was bright and clean, and had menus on display. There was access to a secure courtyard which had a smoking area. A resident using this area told inspectors that there was often a delay in getting assistance when they rang the call bell. Inspectors rang the call bell twice before staff responded. This was also brought to the attention of the ADON.

There were two additional communal rooms along the corridors. The most frequently used was the Garden Room which was seen to be attractively furnished and clean. The second room served as a physiotherapy room, and was also available for use by residents and visitors. Chairs in this room were seen to be unclean, and a coffee table was damaged. A wheelchair and specialised tilt chair were seen to be stored here. The wheelchair was immediately removed to the store room. The tilt chair had been used by a resident who had passed away, and staff were unable to specify how long it had been stored in the room, or when it was to be removed.

The centre had a well furnished hair salon, and a hairdresser attended once a week. Residents using the salon on the day of inspection said they loved the facility, and there was jovial interaction between them and the hairdresser. Prior to residents coming into the salon, inspectors saw the door propped open by a chair. The potential fire risk was highlighted to the ADON, who removed the chair and shut the door.

While all the communal toilets and bathrooms seen on the day were clean and well stocked, one assisted bathroom was seen to have no lock. When this was brought to the attention of the ADON and other staff, there was no record of how long the lock had been missing, or whether a new lock had been requested. Inspectors requested

that the bathroom be cordoned off, maintenance were informed, and a new lock was installed before the end of the inspection.

Inspectors looked at a room that had a Staff Only sign on the door. The door was locked, and the ADON informed inspectors that the room was used as a record store. Inside, inspectors saw residents records, boxes of alcohol, and two oxygen concentrators. These items stored together posed a fire hazard, and this was brought to the attention of the ADON.

The activity schedule detailed the previous days activities, and inspectors observed one Health Care Assistant (HCA) was responsible for supervising 15 residents after Mass had finished. Inspectors were told that staff had rung in sick that morning. An agency staff was sourced, but due to poor oversight of staff allocation, there were no staff allocated to activities duties that morning.

Inspectors saw lunch being served, and it was a relaxed, social occasion. A daily written menu was available and displayed on individual tables with choices seen for the main lunch-time meal, dessert and the evening meal. The portions appeared generous. Residents had the choice to eat in their rooms or the dining room, and there was staff available to assist. However, inspectors observed that one resident being supported with their meal had four different staff assisting them for the duration of their main meal, with various reasons being provided to inspectors for why staff kept swapping out. Inspectors found this did not provide a consistent or dignified dining experience for this resident. Residents and visitors were complimentary of the food on offer, with one resident stating they very much enjoyed the lasagne dish, although another resident who had their meals in their room said that they missed gravy or sauce with their meal.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

Inspectors saw that the provider aimed to provide a good service, but this was not supported by the weakened management structure.

This unannounced inspection was completed to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the actions the provider had committed to in their compliance plan following the previous inspection in May 2025.

The registered provider of Kilminchy Lodge Nursing Home was Kilminchy Lodge Nursing Home Limited, and a representative from the provider was present on the

day of inspection. The person in charge role was supported by two Assistant Directors of Nursing (ADON's), three Clinical Nurse Managers (CNM's), staff nurses, Health Care Assistants (HCA's), and activities, administration, household, kitchen and maintenance staff. On the day of inspection, the provider representative informed inspectors that the person in charge had been absent since 10th June, and had formally left their post on 17th July. This had not been notified to the Chief Inspector as required in Regulation 32: Notification of absence. There was no evidence of deputising arrangements for the period. This will be discussed under Regulation 14: Persons in charge.

Documentation requested for the inspection, including staff Schedule 2 records were available and provided in a timely manner. However, there were gaps in some residents' care records as outlined under Regulation 21: Records.

The provider had an Annual Review for 2024. This was in accordance with relevant standards, and had been prepared in consultation with residents and their families. There was a corresponding Quality Improvement Plan, but not all elements of the plan, such as end-of-life care, had been implemented. This will be discussed under Regulation 23: Governance and management. Although audits and walk arounds had been conducted, they did not identify issues seen by inspectors on the day, and where issues had been highlighted, they were not always addressed. Some of these include repeat findings from previous inspections, and will be discussed under Regulation 23: Governance and management.

There was a comprehensive suite of training in place, including training in medication management and manual handling. Inspectors saw a high level of compliance for all staff. There was an induction system for new staff, but inspectors were not assured that there was adequate supervision after the induction period of one day. This will be discussed under Regulation 16: Training and staff development.

Inspectors looked at a sample of five contracts of care, and while all had been signed correctly, none of the contracts specified the room occupancy. Other gaps are identified under Regulation 24: Contract for the provision of services.

Regulation 16: Training and staff development

Inspectors were not assured that staff were adequately supervised. For example:

- A new staff member had completed paperwork for a resident, despite not delivering the care to the resident. This gave an inaccurate reflection of the nutritional intake of the resident.
- There had been no supervision of a task completed by a staff member. The staff member had finished their shift, and the staff nurse was unable to provide detail on the meal provided or the amount of food the resident had consumed for lunch.

- Staff spoken with were not aware of the correct dietary needs of the residents they had assisted at lunch.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a Directory of Residents accommodated in the designated centre and it was made available on the day of inspection. The directory included all the required information specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Inspectors reviewed five staff files, and they included all the required information specified in Schedule 2 of the regulations. However, inspectors found there were gaps in the completion of records under Schedule 3 and 4 pertaining to resident's care plans, and some of these records were inaccurate. This is evidenced by:

- records of repositioning charts for residents at high risk of impaired skin integrity were seen to have gaps.
- records of food intake for one resident recorded on the electronic system that the resident had their full lunch meal, however staff assisting the resident told inspectors that they ate a half portion.
- records of supervision of residents were inaccurate. For example, a resident on 30 minute monitoring had documented this supervision as completed at 11:30 while inspectors reviewed this document at 11:23.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had a contract of insurance against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The provider did not have a clearly defined management structure, or robust systems in place to ensure safe and effective oversight. For example:

- There was no person in charge since 10th June, and no deputising arrangements had been put in place. This resulted in poor oversight of areas such as staff supervision and care planning, which impacted negatively on the care of residents as evidenced in the findings of this inspection.
- Care plan audits showed recurrent issues arising, but no plan was in place to address the issues. This was a repeat finding from the previous two inspections.
- Walk arounds were conducted by management, but these had not identified multiple concerns found on the day of inspection, such as a bathroom with no lock, inappropriate storage, and a toilet with no call bell.
- No oversight of staff allocation. For example, one resident had four different staff assisting them during the course of one meal.
- The compliance plans from the previous two inspections had not been fully implemented, resulting in continued poor compliance with the regulations.
- The Chief Inspector was not informed of the absence of the person in charge.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed a sample of five residents' contracts for the provision of care and services and found that the terms and conditions of the agreements were not always specified. For example:

- The date the contract was agreed on was missing in one record.
- All contracts reviewed did not have the type of bedroom set out, including the number of other occupants (if any) of that bedroom.
- Two contracts reviewed did not have the accurate bedroom number recorded.
- One contract did not clearly outline the fees to be charged. For example, they did not provide a breakdown of the fees which will be covered under the Nursing Homes Support Scheme (the Fair Deal Scheme) and the amount that was to be covered by the resident concerned.

Judgment: Substantially compliant

Regulation 32: Notification of absence

The provider had not given timely notice to the Chief Inspector that the person in charge was absent since 10th June, and had formally resigned with immediate effect on 17th July.

Judgment: Not compliant

Regulation 14: Persons in charge

There was no person in charge since 10th June, and no deputising arrangements had been put in place for the time period.

Judgment: Not compliant

Quality and safety

Inspectors spoke with a number of residents and visitors on the day who were very complimentary of the care they received, and the staff who worked in the centre. While staff were seen to interact in a respectful and kind manner with residents, inspectors saw gaps in care plans, and delays in referring to allied health professionals which could result in inadequate or incorrect care being delivered.

A selection of residents' records such as assessments and care plans were reviewed on the day of inspection. An assessment was carried out prior to admission to the designated centre, and a comprehensive assessment was carried out within 48 hours of admission to the centre. Inspectors found that many records reviewed contained contradictory information, and overall the registered provider had failed to ensure care plans were reflective of the resident's current care needs. This is further discussed under Regulation 5: Individual assessment and care plan.

Overall, residents had good access to medical and health and social care professionals. The centre's general practitioner (GP) visited the centre four times a week and was contactable by phone outside of these visits. Records evidenced that residents had access to specialist health professionals such as physiotherapy, occupational therapy, dietitians, and speech and language therapy. Residents also had access to local community services such as opticians, dentistry and chiropody. Inspectors were told that residents who met certain criteria were facilitated to access health checks under the national screening programme. However, inspectors found that one resident had not been referred to tissue viability nursing, which is discussed further under Regulation 6: Health care.

Residents with specialist communication requirements had these outlined in their care plans, however inspectors were not assured that residents were facilitated to

communicate freely as there were gaps in these requirements being accommodated at all times. This will be discussed under Regulation 10: Communication difficulties.

The centre had access to specialist palliative care services to provide further support to residents who were at end of life. Records relating to residents' wishes for medical interventions at end of life or in the event of an emergency were clearly documented and made available to staff. However, inspectors found that none of the three end-of-life care plans reviewed outlined residents' holistic wishes.

The centre uses one main pharmacy which delivers regularly, but residents can also choose to retain the services of their own pharmacy. Inspectors looked at the medicine room in the company of nursing staff. There were three medicine trolleys in a tight space which made access to them, and the medication press, difficult. There were chains available to secure the trolleys to the wall, but none were secured, and staff confirmed this was common practice. Each trolley also contained medication that was no longer in use, out of date, or not labelled. A medication audit in June 2025 had identified these issues and documented them as having been actioned. It was also stated that night staff on a certain day each week were responsible for checking the stock on the trolleys, but no checklist or evidence of this was available, and staff did not know who was responsible for the oversight of this activity. Three unlocked pharmacy boxes were on the floor, beside an open window which led to the car park. Staff said this was common practice as there was insufficient space to securely store all the medication when a pharmacy delivery arrived. The window was open to cool the room, which was observed to be very warm. Medication belonging to a discharged resident was in a lunch box beside the open window. Staff did not know how long it was there, or if arrangements had been made for the return of the medication.These issues will be dealt with under Regulation 29: Medicines and pharmaceutical services.

Regulation 10: Communication difficulties

The interventions recorded in care plans to support residents where English is not their first language were not seen to be accurately used. For example, care plans outlined the reliance on staff who spoke this language with measures such as "staff who know and understand this language should be constantly assigned to the resident whenever the person is on duty". Inspectors were told that neither of the two staff employed who spoke this language were working the day of the inspection. Other resources outlined within care plans for communication supports included the use of a translation service on their phone, which inspectors were told was not used in practice.

Judgment: Not compliant

Regulation 13: End of life

While inspectors were assured that residents approaching the end of their life would be provided with comfort and support for their physical needs, three care plans reviewed did not clearly identify the person's wishes for their emotional, social, psychological and spiritual needs. This posed a risk that residents' preferences for end-of-life care would not be met.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider did not ensure safe storage and disposal of medicines. For example:

- Medicines were stored in unlocked boxes next to an open window.
- The medicine room required the window to be opened to cool the room. The room temperature was a finding on the last inspection, and was discussed at a staff nurse meeting in January 2025, but no action was taken to address it.
- Out of date and medication no longer required were not segregated from other medication, and was not disposed of in a timely manner.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Based on the sample of residents' records reviewed, significant action was required in relation to care plans. The registered provider has had repeat findings of non-compliance in this regulation within the last three inspections. For example:

- Care plans were not reviewed or updated when a resident's condition changed. For example:
    - A resident's manual handling assessment stated they were independent with the use of their zimmer frame. However, their mobility care plan outlined they required assistance of one staff with their zimmer frame and used a wheelchair for longer distances.
    - A resident's safe environment assessment referred to using a zimmer frame and wheelchair, however this assessment was not updated following a recommendation from the physiotherapist that this resident now required assistance with the use of a full body hoist.
    - A safeguarding care plan referred to control measures which were no longer relevant.
    - A resident's comprehensive assessment stated they were on a minced and moist diet (Level 5). The nutrition care plan outlined they were on a soft and bite-sized diet (Level 6). This resident had declined a

swallow assessment over two years prior to this inspection, and it was unclear what the recommended appropriate diet level was. In addition, the nutrition assessment stated that the resident was independent with their meals and preferred to dine in their bedroom, however due to a risk of choking, a professional had recommended the resident required general supervision.
    - Another resident's record had recorded a minced and moist diet (Level 5) within their care plan, however the notes from a swallow assessment stated they were on a soft and bite-sized diet (Level 6) and the handover sheet available for the day of the inspection stated they were on a regular diet (Level 7).
- Assessments of residents care needs were incomplete. For example, two residents' incontinence assessments were incomplete and while there were continence care plans which referred to the residents using continence wear, there was no detail relating to the type.
- Care plans were not person-centred. Many care plans reviewed stated the same goals for the residents' care and did not reflect the individual needs of residents in line with their assessments.

This created a risk that staff were not always appropriately guided to provide person-centred and consistent care to residents.

Judgment: Not compliant

Regulation 6: Health care

There was a delay in making a referral to a GP or tissue viability nursing for a resident with a newly acquired pressure ulcer. The management of this wound was also not outlined within the resident's skin integrity care plan, and the resident was refusing repositioning which made them at further risk of tissue damage.

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	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 32: Notification of absence	Not compliant
Regulation 14: Persons in charge	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Not compliant
Regulation 13: End of life	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant

Compliance Plan for Kilminchy Lodge Nursing Home OSV-0000052

Inspection ID: MON-0047408

Date of inspection: 22/07/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • From 25.08.2025 an additional communication forum commenced "Nurse Huddle". This forum is nurse led and nurse focused, allowing for a more in-depth communicative discussion regarding the key relevant points of clinical care for both residents each day, including nutritional intake, dietary requirements and supervision of resident care. A member of the management team is in attendance. • All healthcare staff have been reminded regarding their role in recording accurate and timely input of care delivered to residents- complete • From 23rd July 2025, the following communicative fora faciliate improved communication of essential resident information including resident nutiritonal intake, dietary requirements, staff workload and organisation of work and findings of management walkabouts and supervision ; - daily morning and evening handover, daily safety pause, daily nurse huddle • By the 30th October 2025 all healthcare staff will have received IDDSI training.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: · A staff nurse meeting was held on the 28.07.2025 to discuss the action plan to improve resident assessments and care planning. · By the 30th of August 2025 all assessments and care plans were reviewed by in house management team and updated on the electronic care system- complete. · All healthcare staff have been instructed to adhere to in house policy regarding the	

accurate recording of residents' daily records pertaining to their ADLs and the importance of a time sensitive approach. This has been achieved and oversight and review is ongoing through the following fora;

- Morning and evening handover
- Safety Pause
- Nurse Huddle.

This is monitored daily by PIC and nursing management team and monthly at clinical governance by the Regional Director.

Regulation 23: Governance and management	Not Compliant

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

- During the unplanned absence of the PIC, the Assistant Director of Nursing ADON and the Acting Assistant of Nursing were in charge, supported by CNM cover, over a seven-day period. The provider recognises the importance of their role in ensuring clearly defined management structures which are robust, clearly communicated to all staff and stakeholders, which ensures the safe and effective delivery of care- complete and ongoing
- A change in person in charge was notified to the regulator on 25th July 2025 and the substantive postholder was in place by 15th August 2025
- The roles and responsibilities of the management team were reviewed and are clearly defined- complete.
- As of the 28th of July 2025, daily management walkarounds have been conducted each morning following morning handover by the management team with strict adherence to items that may pose a risk to the centre.
- The bathroom lock was changed on the day of the inspection and inappropriate storage was removed. The call bell which was found to be unplugged on the day of the inspection was replaced- complete
- The use of the internal maintenance system is now used to efficiently and effectively log all items for repair or replacement in a timely manner and oversight is provided by the PIC- complete and ongoing
- From 28th of July 2025, roles for staff during mealtimes will be agreed and communicated daily to the team at Safety Pause.
- From 1st September 2025, the Regional Director will oversee the audits conducted in the home on care plans and will also conduct their own audit during bi-weekly visits to the home. The Regional Director will confirm that complete audits are identifying areas for improvement and that actions agreed will deliver the improvements required.
- From 1st September 2025, the monthly governance meetings, the Regional Director will review progress against agreed action plans (from audits and compliance plans) to ensure that improvements have been achieved and that the home is adhering to the agreed audit programme and improvement plans.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

A review was commenced on the contracts of care to ensure they align to each residents' provision of services and specify date contract was agreed, correct room number, bedroom type and occupancy and charges for services as applicable. This review will be complete by the 30th September 2025.
From 1st October 2025, new contracts and changes for existing residents will be monitored weekly by the PIC and monthly by the Regional Director.

Regulation 32: Notification of absence	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of absence:

A system is now in place to ensure that Regional Directors and the provider representative provide timely informal as well as formal notification to the regulator regarding unplanned and planned absence of the PIC- complete and ongoing
Any absence of the PIC will be covered by an identified individual who is fully aware of their role and responsibilities when deputising and will be supported by the Regional Director- compete and ongoing.

Regulation 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:

• During the unplanned absence of the PIC, the Assistant Director of Nursing ADON and the Acting Assistant of Nursing were in charge, supported by CNM cover, over a seven-day period. The provider recognises the importance of their role in ensuring clearly defined management structures which are robust, clearly communicated to all staff and stakeholders, which ensures the safe and effective delivery of care- complete and ongoing

• A change in person in charge was notified to the regulator on 25th July 2025 and the substantive postholder was in place by 15th August 2025

• The roles and responsibilities of the management team were reviewed and are clearly defined- complete

Regulation 10: Communication difficulties	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:

A review of communication care plans commenced on the 28th July 2025 and was completed by the 30th August 2025.
Person centred communication folders were developed and are available in the individual bedrooms of residents whose first language is not English- complete.
The PIC will continue to review the communication needs to residents to ensure that sustainable arrangements, not reliant on a small number of specific staff, are in place to meet the needs of residents whose first language is not English- complete and ongoing
Care plans are reviewed quarterly or sooner as the need arises- complete and ongoing
Care plan reviews will be monitored by the management team through audit and review weekly following any change in residents' condition, incidents, complaints or updates by the MDT- ongoing
From 1st September 2025, the Regional Director will review feedback from residents and staff monthly while completing clinical governance to ensure that communication arrangements and support for residents whose first language is not English is appropriate

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:

A review of care plans pertaining to End of Life care was conducted and completed by the 30th of August 2025.
Residents' religious beliefs were updated and completed by the 30th August 2025.
Residents' who required additional support from families to express their religious beliefs were contacted and their individual care plans updated to reflect their individual requirements- complete.
From 1st September 2025, care plan reviews will be monitored by the nursing management team and monthly at the Clinical Governance meeting by the Regional Director.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

By the 28th August 2025 a detailed review of the clinical room was conducted by the clinical team.
Out of date medication is now segregated and disposed of in a timely manner- complete and ongoing
To ensure the clinical room remains at a constant temperature, an air filtration system was installed on the 19th August 2025. Daily measurements are recorded using a digital temperature display thermometer- complete and ongoing.
This will be monitored daily during the Daily Manager walkarounds and Monthly at the Clinical governance meeting by the Regional Director.

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 review of care plans was conducted on the 28th July 2025. All resident assessments were reviewed and updated to reflect the resident’s current plan of care. Completed 30th August 2025.

IDDSI Training has been arranged and scheduled for all staff to be completed by 30-10-2025- ongoing.

Handover sheets have been reviewed and amended to reflect changes in the residents’ care plan requirements- completed 30th August 2025.

Handover reports are updated daily by the assigned nurse on duty to reflect any changes in a resident current plan of care- ongoing.

This will be monitored by the nursing management team and monthly at clinical governance by the Regional Director.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Wound management training will commence for all clinical staff on the 22nd of October 2025. This training will include best practice with respect to the early identification of changes to skin integrity, pressure ulcer and their classification.
A review was conducted of care plans to ensure they accurately reflected the individualised management of each resident's skin integrity- complete.
An SOP is now in place to ensure MDT referrals are made in a timely manner- complete.
This will be monitored by the nursing management team and monthly at clinical governance by the Regional Director

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 10(1)	The registered provider shall ensure that a resident, who has communication difficulties is facilitated to communicate freely in accordance with the residents' needs and ability.	Not Compliant	Orange	30/09/2025
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	30/09/2025
Regulation 14(1)(a)	The registered provider shall ensure that the designated centre	Not Compliant	Red	25/07/2025

	has a person in charge.			
Regulation 14(1)(b)	The registered provider shall ensure that the designated centre has a person who is able to deputise in the absence of the person in charge.	Not Compliant	Red	25/07/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/10/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/09/2025
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	Red	25/07/2025
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Not Compliant	Red	25/07/2025

Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	25/07/2025
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e).	Substantially Compliant	Orange	30/09/2025
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to 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.	Substantially Compliant	Yellow	31/10/2025
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care	Substantially Compliant	Yellow	31/10/2025

	and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	30/09/2025
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	30/09/2025
Regulation 32(3)	Where the person in charge is absent as the result of an	Not Compliant	Red	25/07/2025

	emergency, the registered provider shall, as soon as it becomes apparent that the absence concerned will be for a period of 42 days or more, give notice of the absence including the information referred to in paragraph (2) in writing to the Chief Inspector specifying the matters mentioned in paragraph (2).			
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	31/10/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/10/2025

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.	Substantially Compliant	Yellow	31/10/2025