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:	Ennis Road Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Ennis Road, Meelick, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	19 November 2025
Centre ID:	OSV-0005768
Fieldwork ID:	MON-0047783

About the designated centre

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

Ennis Road Care Facility is a designated centre located on the outskirts of Limerick city on the old Ennis Road. It is registered to accommodate a maximum of 84 residents. It is a purpose-built single storey facility, where bedroom accommodation comprises 54 single and 15 twin rooms, all with en-suite facilities of shower, toilet and hand-wash basin. Additional toilet facilities are available throughout the centre. Communal areas comprise a spacious dining room, a large garden room (day room), activities room, smoking room, and oratory. Main reception is an expansive space with a grand piano, fire place, and lots of seating hubs; off the main reception is the hairdressers' salon and an area to be developed into a coffee dock. There are additional comfortable seating areas off the activities room. Residents have access to two enclosed gardens with walkways, seating and raised flower beds. Ennis Road Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	78

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
Wednesday 19 November 2025	09:00hrs to 18:30hrs	Leanne Crowe	Lead
Wednesday 19 November 2025	09:00hrs to 18:30hrs	Sean Ryan	Support

What residents told us and what inspectors observed

This was an unannounced inspection, which was conducted over the course of one day. Inspectors spent periods of time, over the course of the inspection, observing staff and resident engagement. For the most part, residents were complimentary about the care they received, the activities available and the food served to them. For example, "the food here is good, I get exactly what I want" and "the care I get is great here". Inspectors noted that residents' feedback at this inspection was significantly more positive than that received by inspectors at the previous inspection in July 2025.

Inspectors were greeted by members of the management team on arrival at the centre. Inspectors completed a walk around the centre, giving an opportunity to review the living environment and to meet with residents and staff.

During the morning, inspectors saw that staff were busily attending to residents' morning care needs. Trolleys containing linen and required supplies were positioned along the corridors, and staff were seen moving between bedrooms to provide care. Housekeeping staff were also present and engaged in cleaning tasks. However, inspectors observed a small number of instances where residents' privacy was not always promoted by staff, such as cleaning one resident's bedroom while they were resting in bed, or providing personal care to a resident without closing their bedroom door.

Inspectors spoke with residents in communal rooms and in their bedrooms, where residents described their experience of living in the centre. They complimented staff, stating that staff were attentive to their needs. Residents spoke positively about how promptly staff responded to their call bells and how staff frequently checked in to ensure they had everything they needed. They also reported that staff supported them to organise and maintain their bedrooms in line with their preferences. Residents described their night-time experience as generally positive, stating that they used their call bell if assistance was required. Some residents reported that there were occasional delays, but that they understood this to be when staff were busy attending to other residents. Some residents had noticed a recent turnover of staff, with some residents describing this as a positive change while others felt that this impacted their personal routines. For example, one resident told inspectors "while I do like it here, my day depends on the staff", while another said "there are lots of new faces and they don't always know my preferences".

Residents were observed enjoying their meals in the two dining rooms, where there was ample staff available to assist, sit with, and support them in a discreet and sensitive manner. Inspectors observed that the majority of residents were appropriately assisted from their wheelchairs into dining chairs. However, inspectors

observed several staff carrying out manual handling transfers in a manner that was not in line with appropriate moving and handling procedures.

The majority of residents attended the communal day room, which was observed to be a lively space of activity and socialisation. The room was arranged in small seating groups with tables in the centre, and residents were seated according to their preferences, often engaging with others who appeared to be their friends. Visitors were also observed joining residents throughout the day. The area was particularly lively in the afternoon with a variety of activities taking place, including art and crafts, boards games, music, and television viewing. A number of staff were present in the room to assist and respond to residents' needs and requests,and staff were seen to use this time to engage with residents in a meaningful and supportive manner.

Many residents were also meeting with one another or with visitors in the large reception area. Both residents and visitors confirmed that visiting arrangements were unrestricted. Visitors were observed being welcomed by staff as they arrived at the centre.

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

This unannounced risk inspection was carried out over one day by inspectors of social services to:

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended)
- follow up on the actions taken by the provider to address issues of non-compliance found on the last inspection in July 2025 with regard to the governance and oversight of the service
- review unsolicited information received by the Chief Inspector. The information related to concerns regarding the departure of the person in charge, staffing levels, staff turnover, training and development of staff, the quality and suitability of food served to residents and the quality of personal care provided to residents. Some of this information was found to be substantiated on this inspection.

Inspectors observed that the provider had strengthened the systems of management and oversight in the centre, as well as the management and allocation of resources. However, while acknowledging the improvements in the management systems for monitoring the quality and safety of the service, inspectors found that

some aspects of these systems were not fully effective, particularly in relation to the assessment, monitoring and review of residents' health status, the communication of key resident information to staff and the oversight of training and management of training records.

The registered provider of Ennis Road Care Facility is Beech Lodge Care Facility Limited. A director of the company represented the registered provider entity. The organisational structure had changed since the previous inspection in July 2025. A new chief executive officer (CEO) had been appointed to the registered provider entity. This person had been nominated to be a person participating in the management of the centre (PPIM) and was working in the centre on a regular basis. An second assistant director of nursing (ADON) had also been appointed, which provided additional clinical supervision in the centre. The remaining staff complement was comprised of a team of nursing staff, health care assistants, a care co-ordinator, a physiotherapist, catering, housekeeping, activities staff and maintenance staff.

At the time of the inspection, there was no person in charge for the designated centre. Prior to this inspection, the Chief Inspector had received unsolicited information that the person in charge and another member of the nursing management team had departed their respective roles. The registered provider confirmed to inspectors that the previous person in charge had ceased employment approximately two weeks prior to the inspection. While the registered provider had notified the Chief Inspector that a new person in charge had been appointed, this person had not yet commenced their role in the centre and one component of the prescribed information to support this application was outstanding at the time of the inspection.

Since the previous inspection, the provider had commenced the process of developing governance and management systems to ensure a safe and consistent service was being provided to residents. These were being implemented and overseen by the PPIM and wider management team. Key clinical indicators with regard to the quality of care provided to residents were collated on a weekly basis, including data on the incidence of falls, infections, wounds, medication errors and complaints. A programme of clinical and operational audits were being carried out on a scheduled basis. Out-of-hours audits were also being conducted throughout the centre by the management team. The data collected and findings from audits were discussed at senior management team meetings and used to identify any deficits in the service. Action plans were consequently developed and assigned to named individuals for completion.

Notwithstanding the positive changes that that been implemented, inspectors identified that some of the management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. For example, the oversight of staff training and maintenance of training records were not effective. A new system for maintaining staff training records was implemented in September 2025 by the registered provider. Up-to-date data relating to staff training was not available on the day of the inspection, and the provider was unable to confirm whether staff had completed mandatory training required by the

regulations, such as moving and handling practices, fire safety, and safeguarding of vulnerable adults. Records of fire safety training were not available for 27 staff, including staff that had commenced in their roles since September 2025. Therefore, the management team did not have oversight of individual staff members' training requirements. Additionally, inspectors found that records of care provided to residents were not always maintained in line with regulatory requirements.

The systems of communication were not sufficiently robust. Following the previous inspection, as part of the registered provider's response to an urgent compliance plan, an electronic communication system for staff had been implemented to ensure that information relating to residents' care needs were promptly communicated to staff. On the day of the inspection, inspectors observed that a handover sheet was circulated to nursing and care staff, and multiple handover meetings occurred each day. Despite these arrangements, inspectors found that not all staff were not informed of changes to residents' care needs, such as supervision needs or moving and handling needs. Some information on the handover sheet provided to inspectors did not accurately reflect some residents' assessed needs as documented in assessments or care planning documentation. Therefore staff did not have sufficient knowledge of residents' care needs, or up-to-date information to mitigate potential risks to residents.

During the previous inspection, inspectors had identified that a practice of assigning some catering and housekeeping duties to care staff during night duty had impacted on the delivery of care to residents. The registered provider had since increased staffing resources to ensure the cessation of these duties at night time. Staff who spoke with inspectors confirmed that these duties were no longer required to be completed on night duty.

The system for managing complaints had been strengthened since the previous inspection. The registered provider had commenced training in complaints management for all staff. While this was not fully complete at the time of the inspection, records demonstrated that a significant proportion of staff had undertaken this training and further sessions had been planned for the weeks following this inspection. A review of complaint records indicated that expressions of dissatisfaction were now being recorded and managed in line with regulatory requirements, including the details of investigations and any actions taken on foot of the complaints.

On the day of the inspection, the staffing levels and skill mix were observed to be appropriate to meet the assessed health and social care need of the residents accommodated in the centre.

While comprehensive records of training were not available for review, there was evidence that training sessions were scheduled for staff in the weeks following the inspection, including fire safety and complaints management.

Registration Regulation 6: Changes to information supplied for registration purposes

The registered provider had failed to give notice, as soon as practicable, to the Chief Inspector of the intended change in the person in charge of the designated centre.

At the time of this inspection, they had not yet provided one component of the prescribed information in relation to a new person in charge, as required by Schedule 2 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

Judgment: Not compliant

Regulation 15: Staffing

On the day of the inspection, the number and skill mix of staff was appropriate with regard to the needs of the residents and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

According to records made available to inspectors on the day of the inspection, 27 staff did not have up-to-date training in fire safety, including staff that had recently commenced employment in the centre.

A review of training records indicated five staff did not have up-to-date training in safeguarding and six staff did not have up-to-date training in moving and handling practices.

Judgment: Substantially compliant

Regulation 21: Records

Records of specialist treatment and nursing care provided to residents were not appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, some records of enhanced supervision of residents with complex supervision needs were not maintained in line with the residents' care plans.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that management systems were effectively implemented to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- Systems to communicate key clinical information regarding residents' care needs to staff were not fully effective. For example, all staff were not informed of changes to residents care needs, including residents manual handling needs, nutritional risks, supervision needs, and complex medical conditions. Consequently, staff did not demonstrate the required knowledge of some residents' individual support needs to effectively manage the risks to residents
- The management of staff training records was not effective and did not support good oversight of staff training requirements
- While the majority of notifiable incidents had been submitted to the Chief Inspector, in line with regulatory requirements, inspectors noted that an incident recorded in the centre's incident log had not been investigated in line with the centre's safeguarding policy and had not been notified to the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the records found that complaints were recorded, managed and responded to, in line with the regulatory requirements.

Judgment: Compliant

Quality and safety

This inspection found that the provider had taken action in relation to residents' rights in the centre, particularly in promoting choice and ensuring that staff were supported to facilitate residents' preferences in daily life. However, the provider had not ensured that residents' care needs were consistently identified through appropriate and comprehensive assessment of their needs. As a result, some care plans did not accurately reflect residents' care needs which resulted in inconsistent care being provided. In addition, the assessment, monitoring and review of

residents' health status was not effective to ensure the timely referral of residents for further expert assessment when clinically indicated.

A sample of residents' assessments and care plans were reviewed and found that, while all residents had a care plan in place, there plans were not always informed by a comprehensive or accurate assessment of their care needs. Consequently, a number of care plans did not contain up-to-date or reliable information that reflected residents' actual care needs. In addition, some care plans lacked the necessary detail to guide the delivery of care for residents with complex medical or neurological care needs. Inspectors also observed instances where care was not delivered in accordance with residents' care plans, leading to inconsistent and unsupported care practices.

Residents' health care needs were supported by unrestricted access to general practitioner services (GP) when required or requested. There were arrangements in place for residents to be referred to allied health professionals, through appropriate care pathways where required, including access to dietetic services, tissue viability nursing expertise, and physiotherapy. However, where residents had been reviewed by professionals and care recommendations were made, these recommendations were not consistently monitored or followed up. As a result, some residents, exhibiting continued clinical concerns, including ongoing weight-loss, were neither appropriately monitored nor re-referred for further expert assessment, in line with the established procedures within the centre.

The provider had arrangements in place to safeguard and protect residents, supported by a comprehensive policy and procedure that outlined the procedures for safeguarding residents at risk of abuse. Staff demonstrated an understanding of their responsibilities in safeguarding residents, including recognising and responding to allegations of abuse.

The provider had taken action to ensure that residents' rights were upheld within the centre. This was reflected in residents' feedback, which indicated that staff endeavoured to support and promote residents' personal preferences and routines. Residents also stated that they felt their choices were respected by staff.

There was an activity schedule in place, which ensured that residents were provided with opportunities for social engagement and to participate in activities that were aligned to their capacities and capabilities. There were dedicated activity staff allocated to the provision of activities, who ensured that residents could participate in group sessions as well as one-to-one activities, in line with their individual needs and preferences. On the day of the inspection, many residents were observed to be encouraged and supported to partake in the activities that were taking place.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

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

- Residents did not have a comprehensive assessment of their needs completed. For example, some residents who had experienced significant weight loss did not have an appropriate or accurate assessment of their nutritional risk completed. Consequently, the care plan did not detail the interventions necessary to support residents with their nutritional care needs
- Care plans were not guided by a comprehensive assessment of the residents' care needs. Some care plans did not identify interventions in place to support residents who had significant complex care and support needs. Consequently, staff did not have accurate information to guide the care to be provided to the residents
- Where care plans were developed, the registered provider failed to ensure that residents received care in line with their assessed needs and care plans. The care plan for residents with specific mobility and transfer needs and residents who required enhanced supervision did not receive care and support in line with their care plan.

Judgment: Not compliant

Regulation 6: Health care

Not all residents were provided with appropriate medical and health care including a high standard of evidenced-based nursing care in accordance with professional guidance. For example;

- There was no evidence of appropriate action being taken for a resident showing signs and symptoms of clinical deterioration. This included additional monitoring, observation, or referral for further medical assessment if required. This was compounded by ineffective systems to communicate clinical information about residents among the nursing staff
- Recommendations from health care professionals were not appropriately implemented. A resident had been prescribed the use of a hoist for their safe

transfer, however, the hoist was not used during transfers, resulting in unsafe moving and handling practices.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had arrangements in place to safeguard residents and protect them from the risk of abuse. These arrangements were supported by policies and procedures that guided staff practices and outlined the organisations response to safeguarding concerns.

Residents reported that they felt safe living in the centre, highlighting the supportive and respectful manner in which staff engaged with them.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to engage in activities that aligned with their interests and capabilities. There was a number of information notice boards strategically placed to inform residents of the planned daily activities.

Residents has the opportunity to be consulted about, and participate in, the organisation of the designated centre by participating in resident meetings and taking part in resident surveys.

Staff discussed how residents' choice was respected and facilitated in the centre, with residents directing their own care and staff supporting and enabling those preferences.

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	
Registration Regulation 6: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ennis Road Care Facility OSV-0005768

Inspection ID: MON-0047783

Date of inspection: 19/11/2025

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
Registration Regulation 6: Changes to information supplied for registration purposes	Not Compliant

Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes:

A formal notification of the change in Person in Charge was submitted to the Chief Inspector. (Completed 06.11.2025).

The one outstanding Schedule 2 document relating to the new Person in Charge was submitted in full on 21.11.2025 when received from the external third party. (Completed 21.11.2025)

A written procedure has been developed and implemented outlining the requirement to notify HIQA "as soon as practicable" of any proposed or actual changes to:
- Person in Charge
- Provider entity
- Management arrangements
- Any other prescribed registration information. (completed 26.11.2025)

The Registered Provider and senior management team have been briefed on the requirements of Regulation 6 to ensure full understanding of statutory notification obligations. (Completed 21.11.2025)

The importance of timely communication with HIQA has been included in the weekly governance and management meetings as well as the induction processes for relevant personnel. (Completed 21.11.2025)

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Fire Training had been planned prior to the inspection and took place for all staff on 29.11.2025.

Safeguarding Training had been scheduled prior to the inspection for 03.12.2025 and 10.12.2025 and took place on site for staff as planned.

Moving and Handling Training has also been scheduled prior to the inspection on 26.11.2025 and took place on site as planned.

Training forms part of the weekly Governance and Management meetings and the Registered Provider will receive monthly reports on training compliance levels to ensure sustained oversight and resource allocation where required.

Regulation 21: Records	Substantially Compliant

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

The following actions will be implemented to address these findings and to ensure full compliance:

Immediate Review of Affected Records

A comprehensive audit of current residents requiring enhanced supervision has been completed to identify any gaps in documentation.
Care plans and associated supervision records have been reviewed and updated to accurately reflect current assessed needs and prescribed supervision arrangements.

Staff Training and Education

Focused training sessions will be provided to nursing and care staff on:
- Regulatory requirements relating to Schedule 3 records
- Accurate and timely documentation
- Linking daily records with care plan interventions.

This training will be completed by 31.03.2025 and will form part of ongoing professional development.

Strengthening Care Plan Processes

Care plans for residents requiring enhanced supervision will clearly outline the exact recording requirements to ensure staff are fully informed of their documentation responsibilities.
Any changes in supervision needs will trigger a formal review of both the care plan and associated recording systems.

Monitoring and Audit

Weekly audits of enhanced supervision records will be undertaken by the Person in Charge or nominated Clinical Nurse Manager for a period of three months.
Thereafter, monthly audits will be incorporated into the centre's quality assurance programme to ensure sustained compliance.
Audit findings will be discussed at clinical governance meetings and any deficits addressed promptly.

Governance Oversight
The Registered Provider will receive regular reports on documentation compliance as part of the centre's governance and quality assurance framework.

Lessons learned from audits will be used to inform continuous improvement initiatives.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The actions below outline how the provider will come into full compliance.

Strengthening Communication of Clinical Information to Staff

Immediate introduction of a structured Clinical Handover System
A formalised, standardised nursing handover template has been introduced to ensure all key information is communicated at every shift change.

Daily safety huddles are now in place at the start of each shift to highlight:
• Changes in residents' care needs
• Updated risk assessments
• Supervision requirements
• Manual handling updates
• Nutritional and hydration risks.

Care Plan Updates
All residents' care plans and risk assessments have been reviewed to ensure they accurately reflect current needs.
Nursing Staff are now aware that any change in a resident's condition automatically triggers:
• An update to the care plan
• An update to the handover record
• Direct communication to all relevant staff.

Staff Education
All nursing and healthcare staff will complete training on effective communication, documentation standards, and clinical handover processes by 31.03.2025

Previous Compliance Commitments

Revised Night-Time Supervision Arrangements
A comprehensive review of night-time staffing levels and supervision arrangements has been completed.

Night-time staffing levels will be kept under continuous review to ensure they reflect resident dependency and acuity.

Formal Oversight Mechanism
Night staffing rosters will be reviewed weekly by the Person in Charge and monthly by the Registered Provider Representative to ensure that agreed staffing arrangements are maintained.

Escalation Procedure
A formal escalation process is now in place requiring any proposed change to agreed staffing levels to be approved in advance by the Registered Provider and discussed weekly at the Governance and Management Meeting.

Improved Management and Oversight of Staff Training
A full review and reconciliation of the training matrix has been completed.

The Person in Charge will complete a monthly review of training compliance.
A training compliance report will be submitted to the Registered Provider Representative each month.

Safeguarding and Notification Processes
The specific incident identified had been reviewed and investigated at the time of the incident. A formal NF06 has been submitted and notified retrospectively to the Chief Inspector.
A comprehensive review of all incidents over the past six months has been undertaken to ensure no other notifications are outstanding.

All incidents and notifications will now be reviewed weekly by the Person in Charge and CEO at the weekly Governance and Management Meetings. Moving forward all safeguarding incidents will be appropriately managed, investigated and notified to the

Chief Inspector in full compliance with regulations.

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:
The Registered Provider acknowledges the findings of the inspection in relation to Regulation 5 and accepts that assessments and care plans were not consistently completed or implemented in accordance with regulatory requirements.
The provider recognises that comprehensive assessment, person-centred care planning and delivery of care in line with assessed needs are fundamental to safe, effective care.
A structured improvement plan has therefore been developed to address all deficits identified.
An immediate full review of all resident assessments has commenced to ensure that:
• Comprehensive assessments are completed for every resident
• Validated assessment tools are used appropriately
• Assessments accurately reflect current needs and risks.

Specific to nutrition:
All residents will have an up-to-date nutritional assessment completed using a validated tool (MUST) by 28.02.2026.
Any resident identified with weight loss or nutritional risk will have:
• A revised nutritional care plan
• Referral to dietetics where required
• Weekly weights and monitoring as clinically indicated.
A revised assessment schedule has been implemented to ensure that:
• Assessments are completed within 48 hours of admission
• Reassessments occur at least every four months
• Reassessments occur following any significant change in condition.

All current care plans are being reviewed and updated to ensure they are:
• Based on a full assessment of need
• Person-centred
• Specific, measurable and reflective of actual care required
• Inclusive of clear interventions and guidance for staff.

Priority reviews will be undertaken for residents with:
• Nutritional risks
• Complex medical conditions
• Mobility and transfer needs
• Behavioural support or enhanced supervision needs.

A new care planning template has been introduced to ensure:
• Consistency of approach
• Clear linkage between assessment findings and planned interventions
• Documentation of resident preferences and choices.

The Person in Charge and assistant Directors of Nursing will provide direct clinical oversight of all care plan updates.

A targeted review has been undertaken of all residents requiring:
• Enhanced supervision
• Specific mobility and transfer supports
• High-risk interventions.

For these residents:
• Care plans have been updated to clearly specify required supports
• Daily monitoring records have been introduced to evidence that care is delivered as planned
• Staffing levels and skill mix have been reviewed to ensure capacity to meet assessed needs.
Communication Systems Strengthened
Changes to care plans will now be communicated to all staff through:
• Formal handover processes
• Daily safety huddles
• Key information summaries.

Spot checks will be carried out by nursing management to verify that care delivered matches the care plan.
Focused training will be provided to nursing and care staff on:
• Person-centred assessment
• Care planning requirements under Regulation 5
• Nutritional assessment and monitoring
• Documentation standards.

Clinical supervision sessions will be undertaken with nursing staff to support improved care planning practice.
Training to be completed by: 31.03.2025
A structured audit programme has been introduced including:
• Weekly audits of care plans and assessments for the next three months
• Monthly audits thereafter.

Audits will specifically review:
• Quality of assessments
• Linkage between assessment and care plan
• Evidence that care delivered reflects the care plan.

Findings will be:
• Discussed at clinical governance meetings
• Used to inform further training and improvement

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The provider is committed to ensuring that all residents receive timely, appropriate and safe medical and nursing care, and that recommendations from healthcare professionals are consistently implemented.

The following actions have been implemented to address the issues identified:

The specific incident referenced has been fully reviewed by the Person in Charge. Learning from this case has been shared with the nursing team to prevent recurrence.

A formal escalation pathway has been implemented outlining the required actions when a resident shows signs of clinical deterioration, including:
• Increased observations and vital sign monitoring
• Use of early warning tools (e.g., NEWS/clinical observation charts)
• Timely GP or emergency referral where indicated
• Clear documentation of actions taken.

A system of structured nursing reviews for acutely unwell residents has been implemented.

Clinical handover processes have been strengthened to ensure any resident with changing or deteriorating health status is clearly highlighted at every shift change.

All nursing staff will receive refresher training on:
• Recognition of clinical deterioration
• Escalation procedures
• Accurate clinical documentation

Residents who experience any change or deterioration in their condition will receive prompt assessment, monitoring and medical intervention in line with best practice.

The resident referenced is now being transferred strictly in accordance with the prescribed moving and handling plan.
All relevant staff have been briefed regarding the correct transfer method for this resident.

A full review of all residents has been completed to ensure that:
• Physiotherapy, occupational therapy, dietetic and medical recommendations are clearly documented in care plans
• All prescribed equipment and interventions are in place and being used.

Care plans have been updated to clearly reflect:
• Any prescribed equipment (e.g., hoists, slings, specialist chairs)
• Exact methods of transfer and mobility supports

Key clinical recommendations are now highlighted in:
• Daily handover
• Resident information summaries
• Communication logs.

Moving and handling competency assessments will be completed for all relevant staff to ensure they are competent and confident in using prescribed equipment.

A structured nursing handover template has been introduced to ensure that:
Changes in residents' conditions are clearly communicated to all staff.
Daily safety huddles continue to highlight residents requiring close monitoring or specific interventions. These robust communication systems will ensure that all staff have accurate and up-to-date clinical information to guide safe care delivery.

The Person in Charge will conduct weekly audits for the next three months of:
• Clinical observation records
• Escalation of care for unwell residents
• Implementation of professional recommendations.

Findings will be reviewed at monthly clinical governance meetings. Any deficits identified will be addressed promptly through additional training or system improvements.

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
Registration Regulation 6 (1) (a)	The registered provider shall as soon as practicable give notice in writing to the chief inspector of any intended change in the identity of the person in charge of a designated centre for older people.	Not Compliant	Orange	26/11/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	10/12/2025
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.	Substantially Compliant	Yellow	28/02/2026
Regulation 23(1)(d)	The registered provider shall ensure that	Not Compliant	Orange	31/03/2026

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
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	28/02/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/03/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after	Substantially Compliant	Yellow	28/02/2026

	consultation with the resident concerned and where appropriate that resident's family.			
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	28/02/2026
Regulation 6(2)(c)	The person in charge shall, in so 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.	Substantially Compliant	Yellow	28/02/2026