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:	The Residence Carton
Name of provider:	TLC Spectrum Limited
Address of centre:	Tonlegee Road, Raheny, Dublin 5
Type of inspection:	Unannounced
Date of inspection:	01 July 2025
Centre ID:	OSV-0005800
Fieldwork ID:	MON-0047597

About the designated centre

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

TLC Carton is a purpose-built nursing home designed to meet the individual needs of the older person, while facilitating freedom and independence for the more active. TLC Carton is located off the Malahide Road and close to Beaumont Hospital, and can accommodate up to 163 male and female residents over 18 years of age. The building has three storeys consisting of 135 single bedrooms and 14 double/twin bedrooms. Each bedroom has full en-suite facilities, and furniture which includes a television, call bells and a phone. Each floor is serviced by stairwells and passenger lifts and access to outdoors spaces are available on the ground and first floor.
TLC Carton provides long term, respite care and stepdown care to meet the health and social needs of people with low, medium, high and maximum dependencies. The centre provides 24-hour nursing care. The provider's aim is to ensure freedom of choice, promote dignity and respect within a safe, friendly and homely environment that respects the individuality of each resident who chooses to reside in TLC Carton.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	150

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 1 July 2025	05:00hrs to 14:00hrs	Karen McMahon	Lead
Wednesday 2 July 2025	18:00hrs to 21:00hrs	Karen McMahon	Lead
Tuesday 1 July 2025	05:00hrs to 14:00hrs	Catherine Rose Connolly Gargan	Support
Tuesday 1 July 2025	05:00hrs to 14:00hrs	Helena Budzicz	Support
Wednesday 2 July 2025	18:00hrs to 21:00hrs	Helena Budzicz	Support

What residents told us and what inspectors observed

The inspection carried out by three inspectors was conducted over two days, commencing with an early morning inspection on the first day and two inspectors returning the following evening to complete the inspection. The overall feedback from residents was that they liked living in The Residence Carton.

The inspectors spoke with a number of residents and spent time observing residents' routines and care practices in the centre in order to gain insight into the experience of those living there. Residents spoken with were complimentary of the staff and said they were very friendly and caring. The inspectors also spoke with nine visitors, all of whom were positive in their feedback regarding the care their loved ones received. Visitors were complimentary about the staff working in The Residence Carton and many said that they found the management in the centre approachable and responsive to their concerns and feedback. However, inspectors found that some of the governance and management systems in place required improvement to ensure that the service was safe and appropriately monitored.

On arrival at the centre, on the first day, inspectors were met in the reception area by the clinical nurse manager (CNM) on night duty. Inspectors spent time observing interactions in different units and spoke with residents and staff.

The centre is set out over three floors, which are further split into units. On the ground floor, there is one unit, while the first floor is divided into three units referred to as A, B, and C. The second floor is divided into two units. Overall, the premises were clean and well-maintained. There were suitable ancillary services throughout the building, including appropriate hand-washing facilities. However, some fire doors required attention, which will be discussed further in this report.

The majority of residents were still in bed during the first few hours of the inspection due to the early start time. Some residents who display responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were up and walking around the centre, while some were awake in their rooms. Staff were seen to respond to the needs of these residents appropriately, and it was clear that they knew the residents' needs well.

The inspectors visited a number of residents' bedrooms and observed that most were in a good state of repair and were bright, spacious and comfortable. Many of the residents had personalised their rooms with their photographs and other personal possessions from home. The communal sitting and dining rooms on all floors were bright with large windows that gave the residents views of the surrounding areas of the city.

Inspectors found that the supervision and allocation of staff were not always adequate, especially for residents on the second floor. Inspectors observed on the

ground and first floors that there were sufficient night staff to provide personal care to meet the needs of the residents while ensuring that there was always a staff member on the corridor to provide assistance and supervision to other residents. In contrast, inspectors observed that due to the high dependency care needs of residents on the second floor, all staff on duty were frequently in bedrooms providing care, leaving the corridor and other residents unsupervised for prolonged periods of time.

Furthermore, inspectors observed, on all floors, a significant delay in the nursing staff finishing their night shift. Two nurses were still present at 09.30 hours, which was one hour and forty-five minutes after their shift was finished. These nurses were due back on duty later that night, and inspectors were concerned regarding the impact this would have on the quality of care being delivered to residents if staff were not having sufficient rest times between shifts. Staff nurses who spoke with the inspectors said this was due to not having enough time during the night to complete many paperwork-based exercises that they were tasked with, outside of the nightly progress reports, particularly at month-end. A review of clock-in and out reports for staff identified a further 12 occasions where this had happened in the two weeks preceding the inspection.

Following handover from the night staff to the day staff, on the first day of inspection, inspectors observed that some of the carers' duties were task-oriented and not focused on prioritising patient care. On one floor, the senior care assistant and two healthcare assistants on duty were observed setting up trays in the dining room for the day ahead, which would be used to serve meals to residents who chose to eat in their bedrooms, despite catering staff working in the dining room. An agency staff member who was allocated to one floor to help cover an unplanned staff absence was seen to be waiting for thirty minutes to receive directions from senior staff members.

Notice boards located around the centre informed residents regarding the weekly and daily activity schedule, independent advocacy services, safeguarding officers, nominated resident representatives (one for each floor) and the complaints procedure. The inspectors observed residents participating in the social activities scheduled during the inspection; however, the social activities taking place for residents who chose not to participate in large group activities or who preferred to stay in their rooms were limited. This will be further explored under the quality and safety section of this report.

The inspectors observed the residents' lunchtime meal. Most residents choose to eat their meals in the dining room located on each floor. The residents' dining rooms were spacious and well-laid out, with enough space between the tables for residents to move around comfortably and safely as they wished. The daily menu was displayed outside each dining room and on the tables. There was a choice of hot main meal options and a choice of desserts. The residents' lunchtime meal was observed to be well-presented, warm and with ample amounts of food on their plates. However, the breakfast and evening meal experience on the second floor

required review, as residents in their bedrooms waited a long time for their meals or the meals were not offered to them.

All of the residents who spoke with the inspectors over the two days of the inspection spoke highly of the staff working in the centre. One resident described them as "masters" at what they do, while another resident stated the staff were "very attentive" to their needs and always "listened" to them. Inspectors observed throughout the inspection that interactions between staff and residents were gentle, kind and respectful.

Staff who spoke with inspectors for the most part were happy working in the centre, but voiced concern that they did not always have adequate resources to meet the needs of the residents in a safe way and provide appropriate supervision to safeguard vulnerable residents and those with responsive behaviours. Staff mentioned that 'as a result, the residents have to wait when they are calling for our attention, as we are not able to support them with their routines and on time'. Some staff identified the evening time as a particular time when they felt under pressure to provide safe care, as many residents were prone to "sun-downing". Sun-downing is a term used to describe an increase in responsive behaviours in the evening hours into night time.

On the second day of inspection, which took place in the evening, inspectors found that the management team had addressed many of the issues identified to them the previous day. Night time staffing levels had been increased on all floors, and additional day staff were allocated to the second floor, where there was a high number of residents with responsive behaviours and complex care needs. Staff reported positively to the inspectors regarding the impact this had already had on the quality and safety of care being delivered to residents. Inspectors observed the centre to be calm and relaxed during this time, and staff attributed this to the additional resources available to them following the findings of the first day of inspection.

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.

Capacity and capability

Although the provider aimed to provide a good service that optimised residents' rights and quality of life, this inspection found that management and oversight systems that were in place did not ensure that the service was safe and appropriate and that residents' quality of life was optimised. Significant focus and effort were required across a number of regulations, including governance and management, staffing, training and staff supervision, health care, assessments and care plans,

residents' rights and fire safety to improve outcomes for residents and bring the service into compliance with the regulations.

This was an unannounced risk inspection which occurred following the airing of an RTE Investigates programme. Although this centre did not feature in that programme, the centre is one of the 25 nursing homes that are part of the Emeis Group of nursing homes. The purpose of the inspection was to ensure that residents were safe and receiving an appropriate standard of quality care, and to assess the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended).

The registered provider of The Residence Carton is TLC Spectrum Limited, which is part of the Emeis Group. The provider was represented by the company's chief executive officer (CEO) and the regional operations manager. As part of a group that operates a number of designated centres for older people, The Residence Carton designated centre benefits from access to and support from the provider group's resources, including a human resource department, staff training and development, clinical practice development, finance and information technology services.

The designated centre's local management structure consisted of a person in charge who worked full time and was supported by three assistant directors of nursing (ADONs) and six clinical nurse managers. There was an established clinical management team within the designated centre with defined roles and responsibilities. There were clear deputising arrangements in place for when the person in charge was absent. As the person in charge was on annual leave for the days of inspection, one of the ADONs facilitated the two days of inspection.

Inspectors found that staffing was not sufficient to meet the assessed needs of residents. This was evidenced by delayed care and a lack of supervision in some units. Furthermore, there were insufficient staffing resources to provide meaningful activities for residents who are not able to participate in the group activities, who were assessed or who chose to prefer one-to-one activities. Inspectors acknowledge that extra staffing resources were put in place for the second day of inspection following the risks identified during the first day of the inspection. Inspectors were informed by the staff during the second day of the inspection that they were available to provide care for residents on time and when the residents requested it, and the workload, especially at night, was more organised. However, an analysis of the staffing levels by the provider was required to ensure that the extra staffing resources would remain in place and to enable staff on duty to provide safe, efficient, and person-centred care for residents.

While staff had access to mandatory training and training relevant to their roles and responsibilities, inspectors observed that there was not adequate supervision of staff practices in the centre. This is discussed under Regulation 16: Training and staff development.

There was a range of governance and oversight processes in the centre. A review of documentation evidenced that there were management and staff meetings to

discuss key issues relating to the quality and safety of care provision in the centre. An audit schedule was in place and evidence of ongoing auditing being conducted in the centre in areas such as care planning and infection prevention and control. The inspectors found that while auditing was taking place, the processes were not affecting change and driving improvements in the delivery of care and in compliance with the regulations.

A significant number of statutory notifications had been received by the office of the Chief Inspector of Social Services since the last inspection. Inspectors reviewed the incident log and found that all relevant notifications had been submitted. However, a number of notifications had been submitted retrospectively following review of the incident logs, and not within the requested period required by the regulations.

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated, and details on the appeal process should the complainant be unhappy with the investigation conclusion.

The complaints log was made available to the inspectors for review. A number of the closed complaints were reviewed. Inspectors found that complaints were appropriately dealt with and investigated, with the satisfaction level of the complaints with the outcome recorded.

Regulation 15: Staffing

The registered provider did not ensure that there were enough staff to provide care and support for all residents in line with their assessed needs. This was evidenced by:

- All residents on the second floor had needed assistance from two staff members since June. However, no additional staff were provided to ensure that this arrangement did not negatively impact other residents who also required assistance at the same time. This issue was evident during the inspection. For example:
    - Prolonged periods of time on the second floor where there were no staff available to supervise or assist residents in the corridor, or when residents were calling or shouting for help, as they were providing personal care to residents in the privacy of their own bedrooms.
- Lack of staffing resources to provide meaningful one-to-one activities for those residents in their bedrooms, and those who require additional support to engage socially.
- Call-bells were ringing for prolonged periods on the first floor.
- Prolonged medication rounds due to nurses administering residents' medications being required to help with other duties and take phone calls.

- Staff did not always follow up on the guide outlined in the resident's manual handling assessment and used an incorrect technique for resident transfers. This posed a risk of injury to residents.
- Some staff roles were not clearly defined, for example, senior care staff on one floor were involved in preparing and serving residents' breakfast trays and this impacted the staff numbers available to meet residents' care needs during this time.
- The assistance at mealtimes for residents who chose to have their meals in their bedrooms was significantly delayed, as further outlined under Regulation 18: Food and nutrition.

There were currently 12 vacancies for health care assistants in the centre and while recruitment was ongoing, at the time of the inspection no one had been successfully recruited to fill these roles, resulting in staff taking on overtime shifts or using agency staff to fill the gaps.

Judgment: Not compliant

Regulation 16: Training and staff development

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

- Staff did not recognise the sudden use of bed rails as the use of emergency restrictive practices on the first day of the inspection and, as a result, did not follow appropriate in-house policy around the use of emergency restraints.
- Staff were prioritising task-oriented duties over the provision of resident care on one floor, resulting in a significant delay in resident personal care and hygiene needs being met. A number of residents were still observed to be in bed in their night clothes at 12.30pm on the first day of inspection.
- Residents on the second floor were served juices in disposable plastic cups, which did not support a dignified meal experience. Furthermore, there was a delay in serving porridge to residents in their bedrooms, and some residents were not offered a choice at teatime.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to identify the lack of staff resources, identified by inspectors, to ensure the effective and safe provision of care to residents. This is evidenced under regulation 15: Staffing.

The registered provider's oversight of the management systems in place needed strengthening to ensure the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The management systems for allocating residents to units during the pre-admission and admission process required review. It was evident on the day of the inspection that the majority of the residents with high dependency needs and requiring the assistance of two care staff were accommodated on the second floor, while a mixture of residents with lesser care needs were accommodated on the other floors.
- Improvements were required to review staffing resource allocations on a regular basis, taking into consideration not just the nursing hours required per resident but also other factors such as responsive behaviours, safeguarding incidents, the occurrence of unexplained bruising and skin tears, falls, and other incidents, as well as residents' preferred patterns of care.
- Oversight for ensuring residents' rights were maintained and supported required strengthening. For example, inspectors observed that there were institutional practices around bathing and personal hygiene for residents. This is further detailed under Regulation 9: Residents' rights.
- Although a variety of monitoring systems were in place, quality improvement plans were not consistently developed to address known deficits in care planning arrangements, recognition of health care needs of residents and their referral to health care professionals and restrictive practices monitoring, as further identified under Regulation 5: Individual assessment and care plan, Regulation 6: Health care and Regulation 7: Managing behaviour that is challenging.
- Auditing processes required review to be more robust in identifying risk and driving quality improvement. While auditing was taking place, its effectiveness and impact were limited as there was no evidence of the results driving quality improvement, with repeat findings found in some of the audits reviewed, and no action taken.
- While incidents and accidents were recorded on the electronic system, there was no clear analysis completed of incidents unrelated to falls within a unit as part of a quality review. Improvements were not put in place, and staffing level reviews were not conducted.
- Management systems had failed to identify that residents' medication was not administered as prescribed and within safe administration times. This posed a risk to residents that had not been picked up by the provider's own auditing systems.
- The oversight of fire safety precautions was not effective and did not ensure that fire safety risks were identified and addressed in a timely manner. These findings are set out under Regulation 28.

Judgment: Not compliant

Regulation 34: Complaints procedure

Evidence was seen by inspectors that procedures were in place to ensure any complaints received were promptly investigated and managed in line with the centre's complaints policy.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that staff working in the centre were committed to providing high-quality care to residents, and they observed that staff treated residents with respect and kindness throughout the inspection. However, actions were necessary to ensure residents were adequately supported to participate in meaningful social activities that met their interests and in line with their individual capacities and that health care assessments being carried out were appropriate and relevant to the residents' needs. In addition, residents' health and social care needs were not met to a high standard, as evidenced in the relevant regulations.

Some of the residents' care documentation reviewed on this inspection was not kept up-to-date and consequently could not be relied on to clearly direct staff on the care they must provide to meet each resident's needs. The inspectors' findings are discussed under Regulation 5: Individual Assessment and Care Plan.

A review of residents' records found that residents had access to a general practitioner (GP) of their choice, as requested or required. However, they also showed that timely referrals were not always sought and sent for allied health care services such as speech and language therapy and occupational therapy, as evidenced under Regulation 6: Health care.

There was a clear safeguarding policy in place that set out the definitions of terms used, responsibilities for different staff roles, types of abuse and the procedure for reporting abuse when it was disclosed by a resident, reported, or observed. The majority of the staff team (98%) had completed safeguarding training. While a significant number of safeguarding notifications had been submitted to the office of the Chief Inspector of Social Services, on review, inspectors found that all staff were knowledgeable in their roles and responsibilities in recognising and responding to safeguarding incidents. This had resulted in appropriate and timely responses, safeguarding residents in the centre and ensuring all appropriate incidents were notified to the office of the Chief Inspector of Social Services.

During the inspection, the inspectors observed how residents were being served during meals and the dining environment. It was noted that not all residents had a satisfactory mealtime experience during breakfast and evening time, and were not given the support needed for a dignified meal experience. These findings are outlined under Regulation 18: Food and Nutrition.

Although efforts were made to support residents' rights, action was required to eliminate institutional and task-oriented practices occurring and to ensure that approaches to care were person-centred to ensure that residents' rights were protected and upheld. Opportunities for recreational and occupational activities were found to be insufficient. Further detail is provided under Regulation 9: Residents' Rights.

Restrictive practices required action as they were not always managed in accordance with the national restraint policy and guidelines. Inspectors observed one occasion where bed rails were used as an emergency restraint; however, staff did not recognise the practice as emergency restraint and did not follow the appropriate actions around its use, in line with national policy.

While some measures were in place to protect residents from the risk of fire, the inspectors found gaps in residents' evacuation plans. A number of fire doors were noted to have significant gaps in them, making them ineffective in the containment of fire.

Regulation 18: Food and nutrition

The inspectors observed that the mealtime experience for residents required review to come into compliance with the regulations with regard to the following:

Food was not properly served on the second floor:

- Inspectors observed that breakfast for residents who were staying in their bedrooms or in the sitting area beside the nursing station was delayed. While residents were served tea and juices around 08:50 hrs in the morning, the porridge was delayed by more than 1.5 hours.
- Residents on the second floor were served juices in disposable plastic cups. Staff informed inspectors that this has been going on for the last 10 days, as there were not enough cups available.

All residents were not offered a choice at mealtimes:

- Inspectors observed during the second day of the inspection that no late tea was served to three residents in their bedrooms on the second day of the inspection. While other residents had sandwiches and biscuits offered to them, there was no option available on the serving trolley for residents with specialised diets. In addition, the staff did not approach all residents to offer them some refreshments and went on with their personal care duties.

These concerns were communicated to management, who implemented immediate corrective actions to address the issues.

Judgment: Not compliant

Regulation 27: Infection control

The centre was visibly clean. Infection prevention and control (IPC) measures were in place. Staff had access to appropriate IPC training, and all staff had completed this.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. Improvements were required to comply fully with of the requirements of some regulations. For example:

Some aspect of containment required review to ensure they were effective:

- The inspectors found that there were gaps in a number of fire doors, and some of the fire doors were noted not to be closing properly.

The registered provider did not make adequate arrangements for evacuating, where necessary in the event of a fire, all persons in the designated centre and for the safe placement of residents. For example:

- One designated fire exit door from the oratory to the outside of the premises appeared to function on a key lock mechanism. Inspectors noted a key was not available to unlock this door. This observation was brought to the attention of the director of the provider company on the first day of this inspection, who stated that they were waiting on a FSRA and would address any issues that this report identified. Information provided post inspection clarified that this door has never been locked with a key and has a thumb turn mechanism to open. However, inspectors were not assured that all staff working in the centre were aware of this mechanism as it was not demonstrated or explained to inspectors when the lock function was queried.

Personal emergency evacuation plans (PEEPs) prepared for residents did not assess the following to ensure their timely and safe evacuation in the event of a fire in the centre. For example:

- The PEEPs were missing details such as the number of staff required for evacuation and supervision of residents after the evacuation.
- A number of residents' equipment needs to safely evacuate during the day and at night were not up-to-date with their current moving and handling assistive equipment needs.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure assessments and care planning were completed to reflect residents' current needs; examples are as follows:

- Mobility care plans for three residents were not updated according to their changing needs, posing a risk that staff would use an incorrect manual handling process to mobilise the residents.
- Some of the manual handling assessments were not completed, outlining clear instructions for staff on the best way to mobilise residents, for example, from bed to chair. This is a repeated finding from the previous inspection.
- Inspectors reviewed a sample of assessments and care plans and found that the dependency assessment tool used did not correctly reflect the needs of the residents assessed.

Judgment: Not compliant

Regulation 6: Health care

Examples were seen where timely and appropriate referral to health care professionals for further assessment and expertise when clinically indicated was not sought. For example:

- Residents who had experienced a stroke and exhibited side body weakness were not referred to an occupational therapist (OT). While the resident was reviewed by a physiotherapist, the resident remained in bed without a repositioning chart and without an appropriate seating assessment and chair.
- In addition, the swallowing needs of the residents were not reviewed to ensure that residents following stroke and side body weakness received food and fluids of the correct consistency.
- Inspectors observed several residents sitting for a number of hours on the first and second floors in transit wheelchairs with no pressure-relieving devices. Health care records indicated that these wheelchairs were intended for transfers only. Additionally, one resident's records noted a preference for sitting in the transit wheelchair; however, there was no evidence of a re-evaluation conducted by a health care professional in consultation with the resident. This issue has been noted repeatedly in previous inspections.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Restrictive practices were implemented incorrectly and did not comply with the center's policy. For instance, an emergency restrictive practice was applied without conducting an appropriate risk assessment or updating the care plan, which also did not align with national policy.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to protect residents from abuse, including staff training. All recent incidents or allegations of abuse were appropriately investigated and followed their safeguarding policy.

Judgment: Compliant

Regulation 9: Residents' rights

Improvements were required to ensure residents' privacy and dignity is supported and respected, for example:

- Inspectors observed residents sitting in the specialised wheelchairs in front of the television on the first and second floors for most of the morning and in the evening following dinner time. In addition, residents who stayed in their bedrooms did not receive opportunities for meaningful one-to-one activities tailored to their abilities and preferences. Activity records showed that many residents who stayed in their bedrooms were either staying in bed or sleeping throughout the day. As a result, this lack of engagement did not align with the residents' preferences for activities and did not support their ability to enjoy meaningful experiences throughout the day.
- On the first day of the inspection, there was a list of residents who would be offered a shower on that day. Such institutionalised practices do not support person-centred care.
- Two male staff members were assigned to provide personal care to one resident with a documented preference to receive personal care from a female staff member. This was brought to the attention of the staff on the day of the inspection to ensure that resident receive care according to their wishes.

Residents' choice and right to make an informed decision were not always supported. For example:

- Residents with unintentional weight loss did not always have the opportunity to meet with the health care professional to discuss their nutritional needs and treatment plans. In cases where the review was conducted online, the assessments and treatment plans for individual residents were developed remotely, relying solely on information provided by the staff at the centre. Furthermore, although care records indicated that consent was sought and obtained, this process was not properly conducted during the online review. There was no evidence that management identified this issue or took steps to ensure residents received a face-to-face review to aid them in their decision-making.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

During the inspection, it was noted that delays to the medication administration rounds in the morning and at night meant that some residents did not receive their drugs at the times prescribed. The inspectors found delays on some occasions exceeding the safe administration time, which posed a safety risk to the residents. In addition, staff nurses were frequently disturbed during medication rounds to assist other staff or residents, which posed an increased risk for medication error. This is repeated finding from the last inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant

Compliance Plan for The Residence Carton OSV-0005800

Inspection ID: MON-0047597

Date of inspection: 02/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The PIC and the Regional Director completed a comprehensive review of the staffing needs of the centre. Following the review, changes were implemented to address residents' needs, dependency levels, responsive behaviours, and other key performance indicators, with increased numbers of staff and healthcare assistants now rostered to provide additional support on both day and night duty. Complete 2. The PIC will review dependency and changes to the residents needs on a weekly basis and will communicate any needs to staffing changes to the Regional Director. Commenced on 8.8.25 3. The staff nurse and CNM will ensure there is appropriate supervision in the corridor for residents who are seeking assistance during busy times, so residents get help in a timely manner. Commenced from 2.7.25 and ongoing 4. The centre is currently recruiting for 10 HCAs and 4 Staff Nurse vacancies. Four HCAs have already started, while six are in the process of completing Gardaí vetting and other compliance requirements. The four recruited Staff Nurses have completed Gardaí vetting and critical skills work permits. All vacancies are expected to be filled by 30.09.2025 5. The PIC has reviewed the process to provide meaningful one-to-one activities for residents in their bedrooms and those who require additional support to engage socially. A designated activity staff member has been allocated to provide one-to-one meaningful activities based on the assessment completed. The activity lead will provide oversight on a weekly basis and will be overseen by the PIC to address any gaps. Commenced from 28.07.25 6. Daily call bell audits are being conducted by the CNM. The ADON and PIC will oversee that appropriate action is taken to drive quality improvement in this area. Complete since 28.7.25 and ongoing 7. The staffing numbers have been reviewed and additional resources have been provided to ensure residents receive medications in a timely manner. Tool Box talks were provided to all staff and residents on the importance of protected medication rounds and to minimise interruptions during drug administration. The management team will monitor the same during daily walkabouts. Any concerns identified will be addressed with the team immediately. commenced 2.7.25 and ongoing	

8. The management team will monitor medication administration times to spot check any delays in medication administration. This will be further discussed during monthly CGM by the RD by 31.08.25
9. Each resident's mobility needs are clearly identified in the handover sheet which is provided to all staff, including agency staff on commencement of shift. Staff nurse, SHCA and clinical nurse managers will monitor compliance with same during daily walkabouts. Any non-compliance identified in these areas is reported to the senior management in the centre and addressed immediately with staff involved. Commenced from 28.7.25
10. Clear roles and responsibilities have been identified with all staff to enhance smooth breakfast services. The additional staffing resources will further support resident care needs and effectively manage mealtimes. The management team carry out mealtime audits to ensure residents receive timely assistance. Commenced from 28.7.25

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. Additional training on restrictive practices and residents' rights has been organised for all nurses. This will be completed by 30.09.2025.
2. Staffing levels have been reviewed as detailed under regulation 15. Additional supervision measures are taken to monitor that residents' morning care is provided in a timely manner by the CNM, ADON and the PIC. Commenced since 3.7.25
3. Additional cups have been purchased and made available to all the floors. The Housekeeping supervisor will monitor stocks on all the floors. Commenced 28.07.25
4. Clear roles and responsibilities have been identified with all staff to enhance smooth breakfast services. The additional staffing resources will further support resident care needs and effectively manage mealtimes including residents in their bedrooms. The management team carry out mealtime audits to ensure residents receive timely assistance. Commenced from 28.7.25

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The PIC has reviewed the admission process to ensure staffing levels are based on the dependency of the residents in each area and that it responds to the needs of the residents admitted to the centre. Complete and ongoing
2. The PIC will review residents' needs and staffing in each area on a weekly basis and will liaise with the Regional Director for any additional needs in response to residents' dependency and other KPIs. Commenced from 5.8.25 and ongoing
3. The shower list has been removed from use and a resident-led personal care approach

has been implemented to promote person-centred care. The staff nurse has clinical oversight and will monitor shower provision via EPIC to ensure timely delivery in line with resident's individual preference and requests. Complete since 11.7.25
4. The centre holds monthly clinical governance meetings where audit outcomes and quality improvement actions are reviewed to ensure they adequately address identified deficits and to ensure robust follow up to reduce risk to residents. Clinical Nurse Managers will share key learnings from these audits with staff nurses during safety pause meetings to support continuous improvement and to provide assurance that actions agreed are implemented and effective. This process is complete since 28.7.25 and ongoing
5. A review of all residents including residents with stroke and their special needs were completed. This was to ensure all appropriate MDT referrals were completed to include OT and SALT. A tracker is in place to monitor this on an ongoing basis.Complete since 28.7.25
6. Mobility care plans have been reviewed for all residents to ensure correct manual handling needs are identified and updated when there are changes. Complete as of 11.7.25
7. All manual handling assessments were completed to ensure they reflect the current mobility needs of the residents. Complete as of 11.7.25
8. All residents' dependency assessments are completed monthly to ensure they accurately reflect their overall needs. Complete as of 11.7.25
9. Additional training on restrictive practices and residents' rights has been organised for all nurses. This will be completed by 30.09.2025.
10. A risk assessment and care plan was completed for that instant of emergency restraint use. Complete by 3.7.25
11. All incidents and accidents are analysed monthly by the PIC, with consideration given to contributory factors such as staffing levels, staff skill mix, resident individual factors and environmental factors. Findings are reviewed during the monthly Clinical Governance meetings by the Regional Director. This process is complete and ongoing.
12. The additional staffing resources provided will ensure residents receive medications in a timely manner. Toolbox talks were delivered to all staff and residents on the importance of protected medication rounds and to minimise interruptions during drug administration. The management team will monitor the same during daily walkabouts. Any concerns identified will be addressed with the team immediately. The management team will monitor medication administration times to spot check any delays in medication administration by 31.08.2025. This will be further reviewed during the monthly CGM by the RD. Complete and ongoing
13. Remedial action is underway to respond to the gaps in the fire doors. This work will be fully completed by 30.09.25
14. The current PEEP document has been reviewed to include the number of staff required to evacuate, supervise residents after evacuation and the equipment needed. Complete as of 21.07.25

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
1. Additional cups have been purchased and made available to all the floors. The Housekeeping supervisor will monitor stocks on all the floors. Commenced 28.07.25
2. Clear roles and responsibilities have been reiterated, agreed and communicated with all staff to enhance smooth breakfast services for residents. The additional staffing resources will further support resident care needs and effectively manage mealtimes. This include residents in their bedrooms. The management team carry out mealtime audits to ensure residents receive timely assistance. Commenced from 28.07.2025
3. All staff are reminded of the importance of ensuring they offer tea and snacks for all residents as per their individualised care plans. Specialised diet options are available and CNMs/ADONs to spot check if the trolley is arranged with all necessary options from 3.7.25. Complete and ongoing

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Remedial action is underway to respond to the gaps in the fire doors. This will be completed by 30.09.2025.
2. The current PEEP document has been reviewed to include the number of staff required to evacuate, supervise residents after evacuation and the equipment needed. Complete as of 21.07.25
3. All staff have been informed about the thumb-turn lock mechanism on the fire door leading from the Oratory to the outside. A sign has been installed with instructions on how to operate the door. The door is regularly serviced and opens easily. A system is now in place to conduct regular checks to ensure the door remains fully functional and to ensure all staff remain aware of how the door functions.

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:
1. Mobility care plans have been reviewed for all residents to ensure correct manual handling needs are identified and updated when there are changes. Complete as of 11.7.25
2. All manual handling assessments were completed to ensure they reflect the current mobility needs of the residents. Complete as of 11.7.25
3. All residents' dependency assessments are completed monthly to ensure they accurately reflect their overall needs. Complete as of 11.7.25

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. A review of all residents including residents with stroke and their special needs were completed. This was to ensure all appropriate MDT referrals were completed to include OT and SALT. A tracker is in place to monitor this on an ongoing basis. Complete since 28.7.25
2. All residents who require repositioning and pressure relieving mattress have them in place. The CNMs and ADON monitor compliance with same during daily walkabout. Complete since 28.7.25 and ongoing
3. All residents' use of wheelchairs has been reviewed and appropriate referral has been completed by 28.7.25. The PIC will ensure that all appropriate reassessments and re-evaluations are completed as per regulations. The PIC to complete follow-up audits to ensure ongoing compliance.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Additional training on restrictive practices and residents' rights has been organised for all nurses. This will be completed by 30.09.2025.

A risk assessment and care plan was completed for an incident of emergency restraint use. Complete by 3.7.25

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Additional activity resources have been provided to the carers to use between scheduled activities, to engage residents according to their preferences. Complete by 28.7.25
2. The PIC has reviewed the process to provide meaningful one-to-one activities for residents in their bedrooms and those who require additional support to engage socially. A designated activity staff has been allocated to provide one-to-one meaningful activities based on the assessment completed. The activity lead will provide oversight on a weekly basis and will be overseen by the PIC to address any gaps. Commenced since 28.7.25
3. Activity records are monitored weekly by the activity lead and by the PIC on a monthly basis to ensure residents receive meaningful activities in line with their care plan. Commenced 28.7.25
4. The allocation sheet includes information regarding residents' preferences for male or female care. This preference is also documented in each resident's care plan and the staff handover sheet. CNMs and ADONs monitor staff knowledge and compliance with

these preferences on a daily basis. This measure has been complete since 28.07.2025.
5. A resident-led approach to personal care has been implemented to promote the rights and choices of residents in respect of their hygiene needs. The staff nurse has clinical oversight and will monitor provision of personal hygiene to individual residents daily to ensure timely delivery in line with resident's individual preference and requests and compliance with this will be monitored via documented reports in the care management system and through feedback from residents both individually and at the resident council meeting. Complete since 11.7.25
6. The management has commenced a review process with the external provider to enhance and improve face-to-face reviews for all MDT consultations. To be completed by 30.09.25

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. The staffing numbers have been reviewed and additional resources have been provided to ensure residents receive medications in a timely manner. Completed by 28.7.25.
2. Toolbox talks were provided to all staff and residents on the importance of protected medication rounds and to minimise interruption during drug administration. The management team will monitor same on a daily basis during daily walkabouts. Any concerns identified will be address with the team immediately. commenced 2.7.25 and ongoing
3. The management team will monitor medication administration times to spot check any delays in medication administration. This will be further discussed during monthly CGM by the RD by 31.08.25

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2025
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	31/08/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food	Not Compliant	Orange	31/08/2025

	and drink which are properly and safely prepared, cooked and served.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/09/2025
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	Orange	30/09/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/09/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all	Substantially Compliant	Yellow	06/08/2025

	persons in the designated centre and safe placement of residents.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	31/08/2025
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	31/08/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health	Not Compliant	Orange	31/08/2025

	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.			
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.	Not Compliant	Orange	31/08/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/09/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/08/2025

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/08/2025