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:	Marymount University Hospital & Hospice
Name of provider:	Marymount University Hospital & Hospice
Address of centre:	Curraheen Road, Curraheen, Cork
Type of inspection:	Announced
Date of inspection:	03 June 2025
Centre ID:	OSV-0000582
Fieldwork ID:	MON-0045961

About the designated centre

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

Marymount University Hospital and Hospice is a purpose-built facility, on the current site in Curraheen, since 2011. The specialist palliative care service and the designated centre for older adults operate from the same premises. Management and governance arrangements cover both services. There is an educational resource centre on site. The designated centre section provides accommodation for up to 63 older adults. There are beds available for respite residents and also intermediate palliative care beds. Admissions are arranged following a pre-admission assessment. There is 24-hour nursing care provided as well as medical, allied health and pharmacy provision. The building is set in extensive grounds and provides secure parking facilities. The designated centre is laid out over three floors. Resident accommodation is located on all three floors, comprising 51 single bedrooms with en-suite shower rooms and three four-bedded rooms. Residents on the lower ground floor have access to enclosed garden areas and outdoor smoking areas, with plentiful seating. The sitting rooms on the upper floors open out to a communal balcony that affords views of the local countryside.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	56

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 3 June 2025	09:05hrs to 17:00hrs	Siobhan Bourke	Lead
Wednesday 4 June 2025	09:05hrs to 14:30hrs	Siobhan Bourke	Lead
Tuesday 3 June 2025	09:05hrs to 17:00hrs	Erica Mulvihill	Support
Wednesday 4 June 2025	09:05hrs to 14:30hrs	Erica Mulvihill	Support

What residents told us and what inspectors observed

This announced inspection was carried out over two days. Inspectors found that residents living in Marymount University Hospital and Hospice were well cared for and supported to live a good quality life, by a dedicated team of staff, who were well known to residents. In conversation with the inspectors, residents were content about their lived experience in the centre, whereby, many of the residents who spoke with the inspectors described the kindness they experienced from staff. Comments such as "staff couldn't be kinder, " while another resident described the staff as "marvellous" and they were "so blessed" with the care they provided. Residents who spoke with inspectors reported feeling safe living there.

Following an introductory meeting on the first day of the inspection, inspectors spent time walking through the centre, which provided inspectors with an opportunity to introduce themselves to residents and staff. During the two days of the inspection, inspectors met many of the residents living in the centre and spoke with 18 residents in more detail and met with eight visitors. On the first morning of the inspection, some residents were observed to be up and about, while others were having their morning care needs attended to by staff. The inspectors saw that staff knocked and greeted residents in a friendly and respectful manner when entering their bedrooms on both days. Many of the residents told the inspectors that they were looking forward to the activities held in the centre during the days.

Marymount University Hospital and Hospice is registered as a designated centre for older persons and can accommodate 63 residents. Hospice services are provided on the same site, but are not part of the designated centre. The centre is arranged over three floors, namely St. Anne's, St. Camillus' and St. John's ward. Each floor has 17 single bedrooms and one four bedded room, all with ensuite shower, hand wash sinks and toilet facilities. The centre was very clean, and well maintained throughout. The inspectors saw that residents' bedrooms were spacious, with plenty storage for residents' belongings. Many residents' bedrooms were personalised with displays of photographs and items of importance to residents. Televisions in many of the residents' rooms had been upgraded and the inspectors saw that there were clear instructions, regarding their use, available for residents. The inspectors saw that the four-bedded rooms had secure privacy screens, adequate storage space and separate televisions with headsets for each resident.

Residents living on each floor had access to spacious communal rooms, with a large sitting room/dining room and a day room. The inspectors saw that the day rooms on each floor were being refurbished, with one of these rooms completed with new bookshelves, furniture, large screen TV and fire place, providing a homely space for residents. The inspector saw that the day rooms opened out on to a terrace on each floor. The terraces were decorated with lots of plants and colourful flower boxes, with residents and activity staff involved in the upkeep of them. Doors to each floor were unlocked. The inspectors saw that each floor could be accessed by a lift or stairs and a number of residents were seen accessing these, independently, or with

the assistance of staff. Each floor had a hair salon that was fitted with hair wash sinks, mirrors, hairdryers and a specialised bath. Residents had selected the name "silver curls" for these rooms and the inspectors were informed that the hairdresser attended the centre each week. Information boards were available on each floor and displays of weekly activity schedules, complaints procedure and advocacy leaflets were available.

Inspectors observed the dining experience at lunch time and saw that the meals provided were well-presented and looked nutritious. Residents were provided with a choice of main course and dessert, on both days of the inspection. Residents confirmed that they were offered a choice each day. An inspector saw that a resident was offered their own preference at lunch time as they told the inspector they didn't like any of the choices on the day and staff arranged this for them. Assistance was provided by staff for residents who required additional support and these interactions were observed to be kind and respectful. The meal time was seen to be a social occasion on two floors, where both staff and residents spent time talking to each other. On one floor, many of the residents chose to eat in their bedrooms and this choice was respected by staff.

During the inspection, many examples of person-centred care was observed by inspectors. Residents appeared well cared for and were dressed in their own styles and preferences. Staff who spoke with the inspectors were very knowledgeable about residents and their needs. It was evident to inspectors that they were well known to the residents, as they greeted them in a warm, friendly and respectful manner. The inspectors observed that personal care was attended, to a very good standard. Residents told inspectors that they could get up and go to bed, at a time of their choosing and this was respected by staff. Residents had easy access to call bells with some residents wearing wrist call bells, if they preferred them. One resident told the inspector they wore the wrist call bell by day and used the lead one at night and it gave them great security. Residents confirmed to inspectors that staff came when they called for assistance, in a timely manner.

The inspectors saw that there was a schedule of varied activities, held over the seven days of the week that was supported by a team of activity staff and volunteers. Many residents spoke highly of the activities available. On the first day of inspection, a group of residents were participating in a bridge game, while others attended an exercise session, on one of the floors. The activity staff ensured that residents could avail of one-to-one and group activities in line with their preferences and capabilities. Activities available included exercise sessions led by the physiotherapist, gardening, live music and sing-a-longs, art therapy, chair yoga, men’s shed, meditation, and reminiscence.

Residents' views on the running of the centre were sought at quarterly residents' meetings, where feedback was sought from residents on life in the centre, such as meals and activities and any other aspects of the service. It was evident from a review of minutes of these meetings, that issues raised by the residents were actioned by the management team. For example, the head chef attended one of the

meetings to outline the action they had taken to ensure meat served was more tender. New menu cards had also been introduced.

As part of this announced inspection process, residents and their relatives were provided with questionnaires to complete, to obtain their feedback on the service. In total, 17 surveys were received. Overall, residents and their relatives conveyed that residents were happy living in the centre and that they were well looked after by kind and caring staff.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This announced inspection found that Marymount University Hospital and Hospital was a well-managed centre, where the management and staff focused on ongoing improvement to enhance the quality and safety of care for residents living in the centre. The governance and management systems were robust and the centre was well resourced, to ensure that residents were supported to have a good quality of life.

Marymount University Hospital and Hospice is the registered provider for the centre and is registered to accommodate 63 residents. The provider ensured that there was a clearly defined management structure in place, whereby the centre was governed by a board of directors, with the Chief Executive Officer for the centre, accountable to the Chairperson of the Board. The Director of nursing was the designated person in charge of the centre and they reported to the Chief Executive Officer. In November 2024, the Office of the Chief Inspector had been appropriately notified of the absence of the person in charge, due to planned leave and the appointment of an interim Director of Nursing into the role as person in charge for the duration of their absence.

The person in charge was supported in their role by an assistant director of nursing and a team of clinical nurse managers, staff nurses, care staff, activity staff, housekeeping and administrative staff. The management team for the designated centre also included a head of human resources, a quality and risk manager and support from practice development nursing staff.

The provider submitted an application to vary condition one of the centre's registration with regard to changing the services and facilities provided in the designated centre and appropriate documentation was received to grant this application.

The inspectors found there were sufficient resources in place to ensure the effective delivery of care in accordance with the statement of purpose. From a review of the rosters, and from speaking with residents, staff and management, the inspectors found there was an appropriate number and skill mix of staff available to meet the assessed needs of the 56 residents living in the centre during the inspection. Where staff shortages were anticipated due to unplanned leave, agency staff were employed to ensure the rosters were maintained. The provider ensured that staff were provided with training appropriate to their role. Staff members, who spoke with inspectors, were knowledgeable regarding their roles and responsibilities and residents' preferences and assessed needs.

The inspectors reviewed a sample of staff files and saw that they met the requirements of the regulations. Requested records were made available to the inspectors and were seen to be stored securely.

The provider had management systems in place to monitor, evaluate and improve the quality and safety of the service provided to residents. Key clinical risks to residents were monitored and there was a schedule of audits in place that included person centred care planning, restrictive practices, wound care, falls management, safeguarding, nutrition and hydration and infection control. From a review of a sample of audits, it was evident that overall good compliance levels were reflective of the findings on inspection.

There were effective communication systems in place between staff and management in the centre. There were a number of governance committees in place to oversee the quality and safety of care provided to residents such as the executive committee, the quality and safety committee, health and safety committee, risk committee and infection prevention and control. A restrictive practice committee, a subcommittee of the risk committee had been recently established, to promote a restraint free environment for residents. The inspectors saw that a risk newsletter was sent out to staff to raise awareness of any learning arising from near misses and incidents which is good practice.

As a quality improvement plan for the centre, the registered provider had successfully sought accreditation for the centre as an Age Friendly Health System (AFHS) which was based on a person centred model of care delivery. This was in the early stages of implementation at the time of inspection.

An inspector reviewed records of incidents maintained in the centre and from a review of these records, it was evident that required notifications were submitted to the Office of the Chief Inspector.

The inspectors saw that there was a complaints procedure displayed in the centre. Residents who spoke with inspectors were aware how to raise a concern or complaint. The inspectors saw that the complaints procedure had been updated in 2025 to meet the regulatory requirements. However from a review of a sample of complaints, it was evident that complainants were not consistently provided with a written response to inform the complainant of the outcome of the investigation of

the complaint and the process for review as detailed under Regulation 34: Complaints procedure.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The provider submitted an application to vary condition one of the centre's registration. Appropriate information was submitted to support the application as required in the regulations and the variation was granted by the Chief Inspector.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was appropriate to meet the assessed needs of the 56 residents living in the centre, during the days of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

From a review of training records maintained in the centre, the inspectors saw that the person in charge ensured that staff had access to training appropriate to their role. Mandatory training such as safeguarding vulnerable adults, management of responsive behaviour was noted to be up-to-date for staff. A number of staff were overdue annual fire refresher training and the provider assured the inspector that this was scheduled for the week following the inspection. The inspectors saw that care staff had identified with the management team that they would benefit from palliative care and end of life training and this programme was underway at the time of the inspection.

Judgment: Compliant

Regulation 21: Records

An inspector reviewed a sample of staff personnel files. These contained the necessary information, as required by Schedule 2 of the regulations, including evidence of a vetting disclosure, in accordance with the National Vetting Bureau

(Children and Vulnerable Persons) Act 2012. Required records were made available to the inspectors as requested.

Judgment: Compliant

Regulation 23: Governance and management

The centre was well-resourced, ensuring the effective delivery of care in accordance with the statement of purpose. There were effective governance and management arrangements in place and clear lines of accountability. Management systems in place enabled the service to be consistently and effectively monitored to ensure a safe and appropriate services for residents.

Judgment: Compliant

Regulation 30: Volunteers

There were a number of volunteers involved in the designated centre and inspectors saw from a review of records, that roles and responsibilities were clearly set out in writing. Vetting disclosures in accordance with the National Vetting Bureau were available in files reviewed.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in Schedule 4 of the regulations were notified to the Chief Inspector within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

While there was a complaints procedure in place, the inspectors saw that where complaints were received, there was not always a written response provided to the complainant outlining whether the complaint was upheld, the review process and any learnings from the investigation of the complaint as required in the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that the care and support provided to residents was of a good standard, whereby residents were supported to have a good quality of life. Residents living in the centre had good access to health and social care services and opportunities for social engagement. Inspectors found that residents' rights were protected and promoted by staff.

Residents care plans were accessible on an electronic system. The inspectors viewed a sample of six residents' nursing care plans and healthcare records. It was evident that residents had a comprehensive assessment of their needs assessed prior to admission and a care plan developed within 48 hours of their admission. All residents had a detailed record of their preferences and life stories so that staff would know their likes and interests. Overall from a review of residents care plans, it was evident that care plans were developed using validated assessment tools and were person centred and detailed. However, some action was required to ensure that care plans were updated when a resident's condition changed, as outlined under Regulation 5: Individual assessment and care plan.

Residents had good access to medical services. A GP was on site in the centre, five days a week, and was available reviewing residents on both days of the inspection. A full time physiotherapist was also available to provide assessments and treatments as required. Residents' nutritional and hydration needs were assessed and closely monitored in the centre and residents were being monitored for the risk of malnutrition. Where required, referral was made to dietetic services and speech and language therapy services. Residents who required assistance with eating and drinking were provided with this, in a dignified and unhurried manner. Residents could choose to eat their meals in the dining rooms or in their bedrooms.

The inspectors saw that the premises was clean, bright and homely. There was an ongoing programme of maintenance works for the centre and the inspectors saw that the day rooms on each floor were being refurbished and decorated, with one completed at the time of inspection. Residents were encouraged to personalise their bedrooms and the inspectors saw that residents' bedrooms were clean and well maintained.

The fire safety folder was examined and it was evident that quarterly and annual servicing of fire safety equipment was recorded. The provider had undertaken an assessment of fire doors in the centre and works were underway at time of inspection to action the findings of this assessment.

The inspectors observed staff providing person-centred care and support to residents, who experience responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort,

or discomfort with their social or physical environment). The centre maintained a register of any practice that was or may be restrictive. All restrictive practices were risk assessed and consent was obtained prior to commencement of these devices.

There was a varied programme of activities in the centre, which took place over seven days. Residents' rights were promoted in the centre and residents were supported to participate in meaningful social engagement and activities. Residents had access to independent advocacy services, when needed.

Regulation 10: Communication difficulties

Communication requirements for residents who required assistance were seen to be recorded in person-centred care plans. Specific devices were evident for those who required them, with information for staff evident to enable residents to communicate freely. A personalised call bell system for one resident who required it was in use, and usage of white boards and picture cards for communication was evident for other residents who had difficulties with hearing. Staff were seen to be patient and were knowledgeable of the communication needs of the residents. One-to-one activities were evident and were tailored to meet the needs of residents with communication difficulties.

Judgment: Compliant

Regulation 11: Visits

Visiting guidelines had been updated to reflect the recent changes in regulation. Visitors and residents confirmed that visiting was not restrictive and a number of visitors were seen coming and going on the day of inspection.

Judgment: Compliant

Regulation 17: Premises

The inspectors saw that there was a programme of work underway, to redecorate and furnish the three day rooms in the centre, with one of these completed to a very high standard. The premises met the individual and collective needs of residents and residents could easily access the outdoor spaces in the centre. The premises was well maintained throughout.

Judgment: Compliant

Regulation 18: Food and nutrition

The inspectors saw that residents were offered a choice of courses for the lunch time meal and many residents were complimentary regarding the quality and variety of food provided. Residents who required assistance received it, in an unhurried and respectful manner. It was evident that residents who required review by a dietitian or a speech and language therapist, were referred and assessed, in a timely manner. The inspectors saw that drinks and snacks were provided to residents, regularly, throughout both days of inspection.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors saw that transfer records included relevant information, when residents were transferred to acute care. This document contained details of residents' assessed needs to support sharing of and access to information within and between services.

Upon residents' return to the centre, the staff made efforts to ensure that all relevant information was obtained from the hospital.

Judgment: Compliant

Regulation 27: Infection control

The centre had a designated lead for infection prevention and control. Furthermore, one of the clinical nurse managers had also completed the link nurse course, to ensure staff had access to infection prevention and control advice as required. There was evidence of adequate resources in place to ensure residents' bedrooms and the centre was cleaned daily and rooms deep cleaned regularly. There was good oversight of residents who were colonised with (Multi-drug resistant organism) MDROs and guidance was evident in their care plans. The inspectors saw that equipment and the environment were cleaned to a very high standard and residents who spoke with residents confirmed that their rooms were cleaned to a high standard.

Judgment: Compliant

Regulation 28: Fire precautions

The provider ensured there was good oversight of fire precautions in the centre and these were monitored by the fire officer for the centre. Quarterly and annual certification of the fire alarm and equipment was available and reviewed by an inspector. Daily and weekly checks of emergency exits and the fire alarm records were maintained and reviewed. The provider ensured that fire safety drills and simulated evacuations were undertaken in the centre at regular intervals. A review of the fire doors in the centre had been undertaken and staff were on site during the inspection carrying out remedial repairs as required. The provider was in the process of trialling acoustic door holder devices at the time of inspection, as it was recognised that staff were not adhering to the centre's policy on keeping fire doors closed. A number of staff were overdue annual fire training and the provider assured the inspectors that this was scheduled for the week following the inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Notwithstanding some positive findings, some further action was required to ensure assessments and care planning is undertaken in accordance with regulatory requirements. Care plans were not always reviewed following a change in resident's condition. For example, in one file, after a change in a residents cognitive function, the care plans was not updated to reflect this change. The daily skin assessment was not recorded every day, for another resident, where it was known that the resident had a pressure area. In one record, nursing daily notes did not accurately reflect that a resident had a pressure ulcer.

Judgment: Substantially compliant

Regulation 6: Health care

Records reviewed showed that residents received a high standard of evidence based nursing care and there was good oversight of residents' health care needs. Residents had access to GP services, speech and language therapy, dietetic services, occupational therapy services, tissue viability, and physiotherapy services. Residents were reviewed regularly and as required by their GP. Records reviewed evidenced ongoing referral and review of residents, as required. Residents living in the centre had access to medical consultants working within the integrated programme for

older persons, if required. Other community services available to residents included, community palliative care services and community mental health practitioners.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors observed many person-centred interactions between staff and residents. The person in charge ensured that there was a low level of restraint in use in the centre and was working toward a restraint free environment. Evidence of alternate usage of restrictive practice was in place with good oversight and review. Staff were up-to-date with training in how to respond and manage responsive behaviours.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted regarding the running of the centre, through regular resident advocacy meetings and surveys. There was evidence that feedback from residents was acted on by the management team. Residents had access to independent advocacy services as required. There was a schedule of activities available for residents over the seven days of the week which enabled residents to participate in meaningful and interesting activities including group and one-to-one activities.

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 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Marymount University Hospital & Hospice OSV-0000582

Inspection ID: MON-0045961

Date of inspection: 04/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: S.I. No. 628 of 2022 – Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2022- Part 10 Complaints procedure reviewed, and the following actions have been taken: • PPG on Management of Service User Feedback and Complaints has been updated to reflect amendments (June 2025) • Feedback/complaints form reviewed and updated. Plan to circulate in July 2025. • Staff education and training planned for Q3 2025. • The structure of Complaints review has been modified. A Complaints Committee has been set up that will meet once monthly to analyse, review, and learn from complaints. Trends of complaints will be analysed and acted upon. Information disseminated to all relevant stakeholders following meeting. • Standard letter template created and includes details of review process, decision re. complaint (upheld or not upheld), and learning outcomes from the complaint. • MDT collaboration of each complaint to ensure robust management to each complaint.	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: • CNM meeting held, root cause analysis of identified issues (Meeting held 16/06/2025) • Care planning assessment tools in review. Currently liaising with electronic healthcare provider to amend nursing assessment tools in order to align with our current nursing documentation practice	

• Nursing documentation auditing increased to quarterly (Along with our routine audits relating to documentation, we are creating an audit tool to review Care Planning Documentation in SFoP by Q4 2025. This will be completed by CNMs in order to emphasise the importance of accurately updating resident's care plans to reflect their current condition)
Planning of wound care and documentation training underway.

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 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	30/09/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and	Substantially Compliant	Yellow	30/09/2025

	where appropriate that resident's family.			