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:	Eliza Lodge Nursing Home
Name of provider:	Eliza Care Limited
Address of centre:	Boherdurrow, Banagher, Offaly
Type of inspection:	Unannounced
Date of inspection:	06 August 2025
Centre ID:	OSV-0000663
Fieldwork ID:	MON-0046990

About the designated centre

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

Eliza Lodge Nursing Home is a purpose built 50 bed nursing home in a rural setting within driving distance of the town of Banagher in Co Offaly. The designated centre is a single storey premises and accommodates both female and male residents over the age of 18 years. Residents' accommodation is provided in 34 single and eight twin bedrooms, all with full en suite facilities. A variety of communal areas are available to residents including a dining room, sitting rooms and an enclosed garden area. The service employs nurses, carers, activity, catering, household, administration and maintenance staff and offers 24 hour nursing care to residents. Eliza Lodge nursing home caters for residents with long-term, convalescence, respite, palliative and dementia care needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	42

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 August 2025	07:40hrs to 16:55hrs	Niamh Moore	Lead
Wednesday 6 August 2025	07:40hrs to 16:55hrs	Sean Ryan	Support

What residents told us and what inspectors observed

This inspection took place in Eliza Lodge Nursing Home in Banagher, Co Offaly. During this inspection, inspectors spent time observing the care provided to residents, reviewing documentation and speaking with residents and staff. Staff were observed to provide care and support to residents in a caring and respectful manner. Overall, residents said they were happy with the care they received. One resident told inspectors "the staff are the best you can get".

Inspectors arrived to the centre at 07:40am and following a brief discussion with night staff, completed a walk around of the premises. Inspectors were told by night staff that as part of their routine duties, during a night shift, approximately six residents were assisted with personal care such as showering and dressing for the day. During the walk around, the inspectors observed that some residents were up and dressed, while many residents were sleeping in their beds, with their bedroom door open. Following this, inspectors met with the person in charge and members of the senior management team to complete an introductory meeting.

The designated centre is registered for 50 residents with 42 residents living in the centre on the day of the inspection. The building layout is on ground floor level with two separate wings referred to as Shannon and Slieve Bloom. There is a separate day room, dining area, in addition to other spaces for residents' use such as an oratory, a smoking room and outdoor courtyard. Inspectors observed areas of the centre that required maintenance, with wear and tear visible to paint work, rust observed on residents' equipment and, poor segregation and storage.

Residents' accommodation was in 34 single and eight twin bedrooms with en-suite facilities. Bedrooms were warm and clean, and inspectors saw that many residents had personalised their rooms with their belongings and photographs. Residents spoken with told inspectors that they were happy with their bedrooms.

Throughout the day, staff were observed attending to residents' requests for assistance in a courteous and respectful manner. However, inspectors observed that not all residents who were assessed to require and approved to receive one-to-one care consistently received this level of care. This was confirmed by staff who told inspectors that due to the availability of staffing resources, not all residents received their required one-to-one care at all times. This was observed by inspectors to have an impact on the timely delivery of care to residents on the day of the inspection. For example, one resident was not yet supported to get up for the day at 12:00, and another resident asked staff why there was a delay in receiving their lunch and were informed this was due to staff assisting other residents. The risk of inadequate staffing levels was notified to the provider who then took urgent action to address the risk.

Inspectors observed the lunch-time meal and saw that most residents had chosen to eat their meals together in the dining room, while some had their meals delivered on trays to their bedroom. The dining experience was seen to be a relaxed and social occasion. Menus were displayed on dining room tables, and on the day of the inspection residents were offered a choice of sweet and sour chicken or fish pie for the main meal. Residents that required assistance with their meals received support in a caring and dignified manner. Inspectors saw that outside of meal times, residents were offered drinks such as juice and tea. Residents spoke positively about both the quality of the food and the staff who prepared and served their meals. Inspectors also spoke with catering staff, who demonstrated a satisfactory awareness of residents individual preferences, dietary requirements, and nutritional care needs.

Inspectors spoke with residents about their experience of living in the centre. Overall, residents described life in the centre as comfortable and reported that they received kind and patient care. Residents highlighted that staff always acknowledged them in passing, greeting them and made them feel valued and respected. They spoke about their transition into residential care and said staff had been very supportive in helping them to adjust. Residents also added that staff took an interest in them, asking questions about their lives and engaging in conversations about matters that were important to them.

Residents were supported to access independent advocacy services. Inspectors spent time throughout the day in the communal day room, where most residents spent their time. An activities board displayed the planned programme for the day, which included chair exercises, dancing, music and walking. However, inspectors observed that on the day of the inspection, activities did not take place in line with the schedule. In the afternoon, a small group of residents were observed enjoying a colouring activity. However, there was no other structured activity provided for the remaining residents in the day room. Inspectors spoke with two residents who outlined that they were unaware of the activities available, with one stating that knowing the activity schedule would have impacted how they choose to spend their day.

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

Capacity and capability

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). In preparing for this inspection, the inspectors reviewed the compliance plan for the inspection of June 2024, solicited information provided by

the provider and the person in charge as well as unsolicited information received by the Chief Inspector of Social Services.

This inspection found that the provider had an established management structure in place that was responsible and accountable for the provision of safe and quality care to the residents. The provider also had management systems in place to support their governance and oversight of the service. However, inspectors found that the oversight of the staffing levels required to deliver safe and effective care to all residents, including those with complex care needs, was not always consistent or in line with the assessed care needs of residents. This was compounded by uncertainty among the management and staff regarding the actual staffing levels required, to ensure that residents with complex care and supervision needs were appropriately supported. In addition, there was inadequate management of fire safety systems, particularly related to the evacuation of residents in the event of a fire emergency. In light of these potential risks posed to residents, an urgent compliance was issued to the provider. The provider immediately outlined actions to increase staffing levels at the end of this inspection which included an additional staff member rostered day and night, and through an urgent compliance plan outlined planned actions to be taken to bring the centre into compliance with the identified regulations. This plan was accepted by the Chief Inspector.

The registered provider of Eliza Lodge Nursing Home is Eliza Care Limited. This company comprised of three company directors. The management structure supporting the designated centre comprised of a Group General Manager and a Quality and Assurance Lead, both of whom were present during this inspection and were persons participating in the management of the service and provided governance and support to the person in charge. Within the centre, a person in charge was supported by a clinical nurse manager (CNM) in both the clinical aspects of care and in the administration of the service. Inspectors were told of plans to increase this clinical management structure to a total of two CNMs commencing shortly after this inspection.

Some residents who were assessed as requiring a high level of supervision such as one-to-one care, did not have this supervision in place due to a lack of staffing resources. Staff allocated to give individual support to residents with complex care needs were observed to be delegated to duties unrelated to the resident whom they had been assigned to care for. For instance, inspectors observed during this inspection that two residents who required one-to-one support did not consistently receive it. In one case, a resident who required assistance of three staff members often only had two available, with the third staff member reassigned from the general staff complement on an adhoc basis. This meant that the resident had to wait for care until all the required staff were available. One resident told inspectors that their call bell was burnt out from using it to call for the assistance of staff. In addition, a review of the night-time staffing roster found that there was insufficient numbers of staff on duty to meet the evacuation needs of all residents. Inspectors found that a comprehensive assessment of risk in relation to staffing, particularly for night time staffing, had not been completed, and the provider had not fully considered the potential impact of staffing levels on residents care.

There was a staff training and development plan in place, and inspectors saw a high level of compliance in training in areas such as safeguarding, fire safety and manual handling. In addition, the registered provider had identified additional training which was beneficial for staff, such as the roll out of wound management training with plans in place to ensure newer staff had the opportunity to attend. However, staff had not received up-to-date training in some topics as specified in the providers own policies.

There was some evidence of formal supervision in place, for example, staff completed induction training when they commenced employment in the designated centre and where required additional supervision appropriate to the staff role had been implemented. However, staff were not always supervised appropriately and effectively during this inspection. This is further discussed under Regulation 16: Training and staff development.

Many records were provided to inspectors for this inspection, including the hard copy of the directory of residents, which was overall well-maintained. However, some required records were not maintained in line as required by the regulations. For example, staff rosters reviewed did not accurately reflect the staff on duty. This is further discussed under Regulation 21: Records.

There were clear roles and responsibilities outlined for members of the management team. In addition, the registered provider had recently recruited a staff member to assist with developing and overseeing all enhanced care packages. There was evidence of meetings including for committees, and auditing occurring to evaluate the quality of the service. There was an annual review completed for 2024 which evidenced consultation with residents and a quality improvement plan in place for 2025. However, inspectors found that some of these management systems did not ensure safe delivery of care or ensure that, resources were provided in accordance with the centre's statement of purpose. This will be further discussed under Regulation 23: Governance and Management.

A number of incidents, while investigated with some learning outcomes identified and in place, had not been recognised as safeguarding concerns and therefore the relevant notifications, as set out in Schedule 4 of the regulations, had not been submitted to the Chief Inspector.

There were policies on the management of complaints in the centre and the complaints procedure was on display. These identified the personnel to deal with complaints and outlined the complaints process and timelines, in line with legislative requirements. The registered provider had ensured that the nominated complaints and review officers had received suitable training to deal with complaints.

Regulation 15: Staffing

There were insufficient staffing levels in the centre to meet the assessed needs of the residents, or for the size and layout of the centre. For example:

- Two residents who were assessed as requiring one-to-one care did not consistently receive this level of support in line with their assessed needs and care plan. Staff allocated to provide the care were also observed carrying out additional duties, such as administering medication, assisting health care professionals and providing activities.
- One resident was left waiting for care when the staff member assigned to provide their care was not available due to assisting other residents. As a result, care was not provided in line with the resident's expressed preferences or choice.
- Inspectors observed three occasions when a staff member assigned to provide one-to-one care, left the resident to provide support to another resident in a different area of the designated centre. This was confirmed by staff who told inspectors that at times they were required to leave residents to attend to other residents' needs.
- The night time staffing levels were insufficient to meet the needs of all residents. There was an inadequate staffing level to ensure safe evacuation of all residents in the event of a fire emergency.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of staff training records found that some staff had not completed training in relation to medication management annually, as per the registered provider's policy. 75 percent of staff had up-to-date training, the remaining staff required refresher training.

Supervision of staff was not fully effective as it failed to recognise and address the following:

- A resident was receiving nutritional supplements that had not been prescribed or included in their nutritional care plan.
- Records of direct resident care were completed inaccurately at the point of care provision.
- Observation records for a resident had not been completed for up to three hours.
- A record of a residents dietary intake was inaccurate.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a directory of residents established within the designated centre. This directory contained all the required information set out in the regulations, and from a sample review, where there were any admissions and discharges of residents, the directory was up-to-date.

Judgment: Compliant

Regulation 21: Records

The provider had not ensured that all records set out in Schedule 4 were kept in the designated centre and made available for review by the inspectors. For example:

- The rosters provided to inspectors did not include the physiotherapist or members of the senior management team. In addition, the roster reviewed did not accurately record the staff who were working on the day of the inspection.
- The statement of purpose provided to inspectors on the day of the inspection did not match the information contained within the statement of purpose available to residents in communal areas of the centre. For example, despite both documents being dated March 2025, the copy provided to inspectors did not evidence the whole time equivalent for the occupational therapist role.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure there were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- The provider had failed to ensure adequate staffing resources to meet the assessed needs of residents with complex care requirements. Assurances were received from the registered provider in response to the urgent compliance plan that this issue has been addressed.
- The registered provider had committed to 0.25 whole time equivalent of occupational therapy/physiotherapy, 9.75 hours a week. However, inspectors were told that there was no occupational therapist and the physiotherapist was only present in the centre for a maximum of three hours a week. Inspectors were told that group chair exercises did not occur for the last three weeks prior to this inspection.

The provider had failed to ensure that management systems were in place to ensure that the service provided was safe and consistent. This was evidenced by:

- The oversight of staff was inadequate to ensure that residents assessed as requiring enhanced care and supervision consistently received it. For example, inspectors observed occasions where staff who were allocated to provide continuous supervision to a resident were simultaneously carrying out other duties.
- Decisions made on the deployment of staffing resources in the designated centre were not appropriately risk assessed. For example, there was no evidence that the decision not to provide three-to-one care to a resident who was assessed as requiring this level of care had been appropriately risk assessed.
- Management systems in place did not identify the requirement to notify the Chief Inspector on receipt of a safeguarding complaint.
- An investigation was not sufficiently robust. For example, the registered provider did not identify all areas for learning that had been identified by inspectors.
- Oversight arrangements did not consistently ensure that all aspects of the physical environment were maintained to the required standard. As a result, the provider was not in full-compliance with the requirements of Regulation 17: Premises, and some issues previously identified were again noted on this inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not submitted two notifications of safeguarding incidents as required and set out under Schedule 4 of the regulations. One of these was received following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors reviewed a sample of five complaints. There was evidence that complaints, including those received from residents were investigated and concluded as soon as possible, with the complainant informed of the outcome of the investigation and any improvements recommended.

Judgment: Compliant

Quality and safety

Overall, inspectors observed that residents received care from staff that was kind and respectful, and residents reported that they felt safe living in the centre. While all residents had a care plan in place that outlined the interventions and supports required to meet their needs, inspectors observed that care was not always delivered in a timely manner or in line with the residents' care plans, particularly in relation to the provision of activities and supporting residents with complex behavioural and supervision care needs. In addition, this inspection found that the premises, infection prevention and control practices, and fire precautions were not in full compliance with the regulations.

A sample of resident's assessments and care plans were reviewed, and evidenced that the residents' health and social care needs were being assessed using validated tools. Residents' care needs were assessed prior to admission and in further detail on admission to the centre, with care plans commenced within 48 hours to ensure all individual needs were appropriately addressed. Assessments informed the development of care plans that reflected person-centred guidance on the current care needs of the residents.

Residents were assessed prior to the use of any form of restraint in the centre. All restraints were recorded in a restrictive practice register and were reviewed to ensure their continued appropriateness. The centre was home to a number of residents who experienced 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). However, inspectors found that the care and support provided to some residents was not consistently delivered in line with their assessed needs and care plans. This is further discussed under Regulation 7: Managing Behaviours that Challenge.

A review of residents' records found that there was regular communication with residents GP regarding their health care needs. There were referral pathways in place to ensure that residents were directed to appropriate health care professionals for further expert assessment when clinically indicated.

The needs and preferences of residents who had difficulty communicating were identified by staff and effort was made to support residents to communicate their views and needs. Residents who required supportive equipment to communicate were provided with such equipment.

Overall, residents' rights were respected and facilitated in the centre. Most residents could retire to bed and get up when they choose. However, inspectors were told that one resident's personal choice to get up in the morning could not be facilitated owing to routine practices and availability of staff. In addition, inspectors were not

assured that residents were provided opportunities for meaningful engagement. This is further discussed under Regulation 9: Residents' rights.

Since the previous inspection, the provider had taken action to repair the flooring in one of the communal bathrooms used by residents. However, this inspection identified further areas of the premises that required maintenance and repair. This included the flooring in another communal bathroom. While this had been identified by the management team, there was no date for completion of this work. In addition, poor storage provision in store rooms and the inappropriate use of limited storage in the laundry area impacted the infection control procedures in the centre.

The provider had arrangements in place in relation to fire safety. There were checklists which included testing of fire equipment, fire alarm testing, emergency lighting, means of escape and fire exit doors. Residents had personal emergency evacuation plans (PEEP) that detailed their specific care, support, and transfer needs to support the safe and timely evacuation of residents in the event of a fire emergency. However, a review of night-time staffing levels and the absence of a simulated night-time evacuation drill did not provide assurance regarding the safe and timely evacuation of residents, particularly those with complex mobility and transfer needs. As a consequence of these concerns, an urgent compliance plan was issued to the provider. Further findings are discussed under Regulation 28: Fire precautions.

Arrangements were in place for residents to access appropriate pharmaceutical services. Inspectors found that overall the centre implemented procedures, underpinned by policies to ensure safe medication management practices were in place, with the exception of one incident.

Regulation 10: Communication difficulties

The registered provider had arrangements in place to ensure residents who experienced communications difficulties were appropriately assessed, and supported to enable residents to make informed choices and decisions.

Staff demonstrated an appropriate knowledge of each residents communications needs, and the aids and appliances required by some residents to support their needs.

Judgment: Compliant

Regulation 17: Premises

The premises did not fully meet the requirements of Schedule 6 of the regulations. For example;

- Some parts of the interior of the centre were not well maintained. This included scuffed and chipped paintwork along corridors and skirting boards, and rust seen on residents' equipment such as raised toilet seats and grab rails.
- There was inappropriate storage seen, such as:
    - There was inadequate storage in the laundry room. For example, cups were stored in a hand wash basin, and dry goods and cutlery were stored beneath another sink.
    - Some store rooms such as housekeeping rooms were disorganised. For example, these rooms contained fuse boards, had cleaning equipment such as hoovers, charging points for hoists, and also stored clinical items such as face masks and continence wear.
    - Some toiletries belonging to individual residents such as sudocream, and a urinal were stored in a communal bathroom.
- There was evidence of a leak from a laundry machine. While staff confirmed there was a leak for some time, they were unsure if this had been escalated to the maintenance team.
- In a communal bathroom, the floor lining was in a poor state of repair. The lining was lifting away from the wall edges and this impacted on effective cleaning of the area.

Judgment: Substantially compliant

Regulation 27: Infection control

This regulation was not reviewed in its entirety, however inspectors observed that the infection prevention and control procedures were not consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA. For example, the environment and equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- Floors, walls and surfaces of furniture were damaged which impacted on the effective cleaning of these areas.
- The laundry facilities did not ensure that infection prevention and control standards could be met to reduce the risk of cross infection. There was no clear segregation between the clean and dirty work-flow, and clean clothing was observed folded on top of a washing machine located in the dirty area.
- A urinal was stored on a window-sill in a communal bathroom. This practice increases the risk of environmental contamination and cross infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Following this inspection, the provider was required to submit an urgent compliance plan to address the urgent risk with regard to the lack of assurance provided on the safe and timely evacuation of residents from the centre. Staff were unclear with regard to the number of staff required to ensure the safe transfer of a resident in the event of a fire emergency. No fire drill had been carried out to reflect night-time conditions, when staffing levels are at their minimum, particularly in the case of residents with complex mobility and evacuation needs, whose safe evacuation required specific planning and appropriate staff availability. The providers urgent compliance plan response provided assurance that the risk was adequately reviewed and addressed.

Arrangements for containing fire in the designated centre was not adequate. This was evidenced by;

- Doors to ancillary storage areas were left open, unattended and were catching on the floor. This included a room where electrical devices were charging and also contained an electrical board. In another area, a door was obstructed by the floor surface which prevented proper closure. This posed a risk to ensuring effective fire containment.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Residents were provided with appropriate access to pharmaceutical services and a pharmacist who was acceptable and accessible to the residents. There were appropriate procedures for the handling and disposal of unused and out of-date medicines, including controlled drugs.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents' care plans were developed following assessment of need using validated assessment tools. Care plans were seen to be person-centred, and updated at regular intervals.

Judgment: Compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of GP who attended the centre as required or requested.

There were referral pathways in place to ensure that residents could be referred for further expert assessment when clinically indicated or at the residents' request. Evidence showed that recommendations made by health care professionals following such assessments were incorporated into the residents' individual care plans and implemented in practice.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Not all staff responsible for the care of residents with complex care and supervision needs demonstrated adequate knowledge of residents' individual supports and interventions required to support residents to manage their responsive behaviours. This included de-escalation techniques and therapeutic interventions.

In addition, some residents who required enhanced supervision as a result of their complex behavioural and support needs were not consistently supervised in accordance with their assessed needs and care plans.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors were not assured that all residents had opportunities to participate in activities in accordance with their interests and capacities. For example:

- Inspectors observed that the staff member assigned to activity provision was also tasked with assisting residents with their care during the morning time. This impacted on residents who were seen to have had limited stimulation and meaningful activities. There was an over reliance of the television for activities during this inspection. For instance, the activity schedule outlined mass on television as the only activity up until 1130am, and music was playing on the television in the afternoon.
- Some residents were not provided with adequate opportunities to participate in activities that reflected their individual capacities and preferences. For

example, a resident who required the provision of person-centred activities as a therapeutic intervention to support the management of their complex care needs were not provided with such activities. This was observed by inspectors, and confirmed by staff.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Eliza Lodge Nursing Home OSV-0000663

Inspection ID: MON-0046990

Date of inspection: 06/08/2025

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: Compliance Plan • Maintain rosters that meet assessed needs, with clear allocation sheets for residents on one-to-one care. The allocation sheet has been amended. 11.08.25 • Continue daily staffing review by PIC and Senior Management Team as required and adjust promptly for changes in residents' needs. 11.08.25 • Reinforce the Supervision of Residents Policy requirement that residents on one-to-one are not left to attend to the needs of other residents, unless another staff member is in place. This will be discussed with staff during handover over, and will also be monitored and audited by PIC and Senior Management Team 30.09.25 • Deliver targeted staff re-briefing on one-to-one supervision expectations and call bell protocol. 31.08.25 • Continue to monitor KPI data on falls, incidents, pressure ulcers prevalence, and call bell response time audits to ensure staffing effectiveness and continued care quality control. 11.08.25 • Review sensor mat and alarm use periodically to ensure ongoing alignment with assessed needs. • Maintain effective and appropriate oversight for Residents who present with complex assessed risk, in line with individual care plans. 11.08.25 & ongoing • Review system for staff allocation and workflows for residents requiring additional supervision/support to ensure alignment with care plan and assessed needs. 30.10.25	

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Compliance Plan
• Reinforcement of Supervision Policy — All nursing and care staff will receive guidance to ensure that they fully understand that leaving a resident on 1:1 support to attend another resident is not permitted unless another designated staff member is in place to maintain continuous supervision. 31.08.25.
• Record-Keeping — Allocation and supervision records will be reviewed at the end of each shift to ensure completion and accuracy. 11.08.25
• Targeted Staff Support/Re-Education — PIC/ CNMs to hold small group sessions with staff identified as having deviated from the allocated roles in with respect to supervision and monitoring required as per the assessed needs of individual residents. 31.08.25
• Enhanced Monitoring — Governance review to review relevant resident supervision/oversight documentation weekly, providing individual feedback where lapses are identified. First review and feedback to be completed 30.09.25
• Staff Allocation— Staff allocations will be reviewed and improved where required to ensure, insofar as is reasonably practicable, that new staff understand their role, requirements and support available for residents requiring additional support/supervision. 30.09.25
• Induction Content and Guidance will specifically cover relevant information with regard to care needs, risks, and preferred approaches for residents requiring additional supervision. 30.09.25
• Resident-Specific Information — Relevant resident specific information will continue to be available outlining care plans, activity plans, and other relevant information for staff reference. These will continue to be available to staff, so that they have ongoing opportunities to review and understand resident care needs. 11.08.25
• Needs-Based Staff Allocation Throughout the Day — Allocation will consider varying care needs at different times, assigning more experienced staff during periods of higher complexity. 31.08.25

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Staff Rosters: The PIC will ensure that staff rosters accurately reflect all direct care staff and other staff rostered to work in the designated centre on each shift, and that rosters are completed, maintained, and retained in line with Schedule 4 requirements. 11.08.25
• Statement of Purpose: Review and reconcile all versions of the Statement of Purpose with guidance and requirements to ensure consistency and accuracy and ensure that the version available to residents and the version held by management are aligned and up to date. 30.09.25

Regulation 23: Governance and management	Not Compliant

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

Regulation 23(1)(a) – Sufficient Resources

• Maintain staffing rosters aligned to residents assessed needs. Continue to assess the needs of residents and maintain ongoing review to inform of resources required for the safe delivery of care. 11.08.25

• Person in Charge (PIC), with support from Senior Management and and where required, will continue to review staffing allocations daily and make timely adjustments to reflect any change in resident needs. 11.08.25

• Weekly Key Performance Indicator (KPI) reviews will be continued to monitor incidents, falls, responsive behaviours, absconsion risk, and skin integrity trends etc. to support staffing effectiveness and inform resource deployment 11.08.25

• Maintain oversight arrangements to support safe care delivery for all residents, ensuring resources are applied in line with assessed needs and individual care plans. Continued with regular reviews, audits of supervision, Care plans etc. 30.09.25

• Continued engagement with relevant stakeholders, as required, regarding the suitability and effectiveness of resource arrangements. 11.08.25

Regulation 23(1)(d) – Governance and Management Systems

• Maintain onsite management and clinical oversight arrangements appropriate to the size, layout and the needs of the centre. This will ensure appropriate on-floor leadership and support required to ensure the continued safe delivery of care. 11.08.25

• Continue structured Operations & Clinical Support Meetings and Governance Meetings, with all actions recorded in formal minutes and tracked as required. 11.08.25

• Continued internal review and audits to ensure and verify alignment with each resident's assessed needs and care plan (first audit to be completed by 30.09.2025).

• Maintain escalation processes for any identified staffing or supervision shortfall, with timely corrective action by the PIC or nurse in charge. 11.08.25

• Continue to retain and maintain centralised governance records, ensuring that all documents and data are available for immediate review during inspections. 11.08.25

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The Person in Charge will review all incidents, reports, complaints etc weekly to ensure that any notifiable events are identified and submitted within statutory timeframes.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Repair and Maintenance of Damaged Surfaces
Damaged or worn floors, walls, and items of furniture will be identified, prioritised, and repaired or replaced to ensure that all areas of the premises are maintained in a good state of repair 30.06.26

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Environmental Maintenance
Damaged floors, walls, and furniture surfaces will be reviewed and repaired or replaced to ensure that all areas can be effectively cleaned and maintained in a hygienic condition. 30.06.26
• Laundry processes will be reviewed to ensure clear segregation between clean and dirty workflows. Clean clothing will not be handled or stored in dirty areas to minimise the risk of cross infection. 31.08.25
• Storage of Equipment
Reusable equipment and residents' personal items will be stored appropriately in designated areas and not in communal bathrooms or other clinical environments where there is a risk of environmental contamination. 31.08.25

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider confirms that these arrangements remain embedded in day-to-day practice and will continue to be applied and reviewed to ensure that residents can be evacuated safely and effectively in the event of a fire, in line with the requirements of Regulation 28.

Compliance Plan

• Updated Drill Schedule: The fire drill programme will include at least one night-time drill every six months, in addition to varied daytime drills.
• Resident-Specific Planning: PEEPs for all residents with mobility restrictions are reviewed quarterly, and immediately if there is a change in health status or mobility, to ensure evacuation planning remains current. 11.08.25

• The Evacuation folder is checked daily to ensure accuracy in terms of resident present in the nursing home, changes in evacuation needs etc., this will continue. 11.08.25

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:
• A member of the Senior Management Team has completed a course of study on '' Positive Behaviour Training, foundation trainer plus" and will provide targeted briefings/ training to nursing and care staff caring for residents with responsive behaviours to reinforce understanding of residents' individual behaviour support strategies, triggers, and agreed responses as outlined in existing care plans. 31.01.26
• PIC and CNMs will continue to monitor supervision arrangements for residents as per assessed care needs to ensure that supervision is delivered consistently in line with assessed needs and documented care plans. 11.08.25
• Staff will continue to be supported to understand and apply least restrictive, person-centred approaches when providing enhanced supervision. This includes recognising that constant or close supervision may impact on a resident's emotional wellbeing or escalate responsive behaviours and ensuring that supervision is tailored to each resident's assessed needs, preferences, wishes, and level of understanding, while maintaining safety. 11.08.25

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Religious and cultural activities, including Mass, will continue to be facilitated in line with residents' wishes and beliefs. Where religious observance is scheduled, the Activity Coordinator will ensure that alternative meaningful activities are made available to residents who choose not to participate, in accordance with their interests and capacities. 11.08.25
• Residents identified as requiring person-centred activities as a therapeutic intervention will continue to be supported to engage in line with their individual plans. Where a resident is unable to participate due to changes in health status, pain, distress, or cognitive impairment, this will be clearly documented and communicated, and alternative supportive approaches will be considered in line with the resident's needs and wishes. The Person in Charge and Clinical Nurse Managers will ensure that staff are kept informed and updated regarding residents' activity requirements and any changes in ability to engage, to support consistent and appropriate activity provision. 11.08.25
• The Person in Charge will ensure that the activity programme reflects the interests, capacities and preferences of residents. The activity plan is currently under review as part of the planned 2026 activity monthly review cycle. Ongoing

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	Red	30/10/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	30/06/2026

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/09/2025
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	Red	11/08/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	30/09/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in	Substantially Compliant	Yellow	30/06/2026

	place and are implemented by staff.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	11/08/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	11/08/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	11/08/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and	Substantially Compliant	Yellow	31/01/2026

	manage behaviour that is challenging.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	31/01/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	11/08/2025