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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:	Leopardstown Park Hospital
Name of provider:	Leopardstown Park Hospital
Address of centre:	Foxrock, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	13 October 2025
Centre ID:	OSV-0000667
Fieldwork ID:	MON-0046254

## About the designated centre

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

Leopardstown Park Hospital provides care for adults who have long term needs for residential care. The centre provides services for residents with low dependency through to those residents who are maximum dependency and require full time nursing care, including care for residents who have dementia and for residents who need end of life care. Accommodation is provided across five units accommodating 120 male and female residents. Clevis unit has 29 beds and provides accommodation and services for residents who have low dependencies. The other four units provide accommodation and services for residents with higher levels of need and are located within the main hospital building. Glencullen and Glencree commonly known as the Glens units provide accommodation for 21 residents in Glencree and 22 residents in Glencullen, in a mix of single and multi-occupancy rooms. Orchard and Avoca units were recently renovated and both provides accommodation for 20 residents each. Djouce unit was also recently refurbished and accommodates 8 residents. There are garden areas to the front and rear of the property with seating available for residents. There is a large car park to the front of the building with some disabled parking spaces available.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	115
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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
Monday 13 October 2025	08:15hrs to 16:30hrs	Laurena Guinan	Lead
Monday 13 October 2025	08:15hrs to 16:30hrs	Sharon Boyle	Support
Monday 13 October 2025	08:15hrs to 16:30hrs	Sarah Armstrong	Support

## What residents told us and what inspectors observed

Residents living in Leopardstown Park Hospital spoke highly of the staff that cared for them. One resident told inspectors "the staff are great, they're excellent actually". Another resident explained to inspectors how staff provided care at the resident's own pace and respected the residents' wishes, stating "the staff don't make a fuss about things. They don't rush me and if I decide not to do something, that is ok". Residents also provided positive feedback on the food provided and told inspectors that they always had a choice of food at meal times.

The centre comprises of a period property that has been refurbished and extended, surrounded by extensive green areas. There were six residential units. Glencullen, Glencree, Orchard, Avoca and Djouce units were within the main building, and the Clevis unit was in close proximity to, but detached from, the main building. Services such as a laundry, kitchen, oratory, auditorium and offices were also located in the main building. There was also a day unit accommodated in the main building, however this was operated separately to the designated centre.

On arrival, the inspectors walked around the units and main building. Each unit had its own dining and sitting areas. The furniture in the combined dining/sitting area in the Glencree unit was dining tables and chairs, and the dining/sitting area in the Djouce unit was set up as a dining room only. This did not make for a homely environment for residents who chose to spend a length of time in these areas. Throughout the units, the inspectors observed missing and broken call-bells in communal rooms, such as visitors' and dining rooms. On the Orchard unit, the visitors' rooms were seen to be used as storage rooms. This will be discussed under Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration. The visitors' rooms on the Glencree, Glencullen and Avoca units were seen to be sparsely furnished and did not promote a comfortable, welcoming environment for residents to receive their visitors in. The flooring in the visitors' room on the Glencree unit was in a state of disrepair, and there were areas of damaged skirting, walls and ceilings in the Djouce unit. These are repeat findings and will be discussed later in the report. The Clevis unit was seen to be attractively furnished, clean and well-maintained.

All residents had access to outdoor areas, with appropriately equipped smoking areas available on some of the units, and a newly built smoking area for the Clevis unit. However, a courtyard attached to the Djouce unit had a 'no smoking' sign on the door, but the inspectors saw three ashtrays in the courtyard, one of which was plastic, as well as a bin containing paper and cigarettes. Residents in the Djouce unit told the inspectors that the reason they used this area as a smoking area was due to the nearest designated smoking area being some distance away, which made it difficult for those with mobility issues to access easily and independently.

The Glencree area had unrestricted access to a courtyard from the dining area. The courtyard was secured by fencing and a gate with a keypad lock system. The inspectors found this gate open, with the lock system detached from the gate. This was brought to the attention of staff and management on the unit, as well as the person in charge, who were unaware of how long the gate had been broken. There was no record of it on the maintenance system. Management on the unit secured the gate immediately and reported it to the maintenance department.

The 'activity of the day' on the day of the inspection was a music concert which was held in the auditorium. Inspectors observed approximately 30 residents listening to and enjoying the music. However, there were no other planned activities for the residents who did not want, or were unable, to attend the auditorium. While there was an activities schedule provided to inspectors, this was not displayed on the units in the main building, and the only scheduled activity staff and residents were aware of was the 'activity of the day'. On each unit, inspectors saw residents sitting in the dining area with a TV on, but in the Glencree, Glencullen and Orchard units many of the residents were not facing the TV. Some residents told inspectors "I don't really join in the activities, they don't interest me" and "in the better weather I like to tend to the garden and look after the plants but that's all. I don't do that now in the damp weather". Other residents said they enjoyed the activities, but that if you chose not to attend the group activity, 'you would be bored'. However, the residents in the Clevis unit, which caters for people who are largely independent, enjoyed an active, varied schedule of activities. This included gardening, DIY and arts and crafts, and the residents were also preparing for an upcoming fashion show.

Inspectors observed the meal time experience for residents. Staff were observed communicating with residents, explaining the menu options and offering residents a choice of both foods and beverages. Some residents required assistance with their meals. Where this was the case, staff were seated next to the residents and were providing unrushed support, and were engaged in conversation with the residents throughout. Staff were observed taking a person-centred approach to the care they provided, and supported residents in their right to dine with dignity.

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 impact on the quality and safety of the service being delivered.

## Capacity and capability

This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also followed up on the compliance plan from the previous inspection, and statutory notifications submitted to the Office of the Chief Inspector since the last inspection in January 2025.

Leopardstown Park Hospital is the registered provider for the designated centre. The person in charge worked full-time in the centre and was supported in their role by an assistant director of nursing, clinical nurse managers, and a team of nurses, healthcare assistants, and activities, housekeeping, kitchen, maintenance and administration staff.

Inspectors found that all staff were seen to be working within the confines of the registered designated centre on the day of the inspection. While there was an adequate number and skill mix of staff, a review of staffing was required to ensure that all residents had access to a comprehensive schedule of activities. Inspectors observed residents spending long periods of time without any meaningful engagement in some of the units.

Inspectors also identified that the registered provider had changed the functions of some rooms within the designated centre, without informing the Office of the Chief Inspector of those intended changes. As a result, the registered provider was in breach of Condition 1 of their registration. This is further discussed under Registration Regulation 7: Applications by registered providers for the variation or removal of conditions.

Records reviewed described regular management, staff and residents' meetings occurring. However, there were no action plans developed to address issues raised, which left issues discussed at these meetings unresolved, sometimes for an extended length of time. The inspectors saw that some audits and analyses had been conducted, and these also did not have action plans developed to address the gaps identified. This will be discussed under Regulation 23: Governance and management, and Regulation 9: Residents' rights. The inspectors followed up on the compliance plan from the previous inspection in January 2025 and found many of the items were not completed in full, or were outstanding, despite the allocated timeframe for completing these having lapsed. These included maintenance issues, review of activities and fire safety precautions.

The inspectors reviewed records of incidents that had occurred in the centre since the date of the last inspection. While all specified incidents had been notified to the Office of the Chief Inspector, inspectors found that these were not always submitted in line with the required time frames as set out in the regulations. This is discussed further under Regulation 31: Notification of incidents.

The registered provider had committed to reviewing the directory of residents in their compliance plan from the previous inspection. While the registered provider had taken some action to ensure information as required in Schedule 3 was included, a number of records were missing required fields of information. This will be discussed under Regulation 19: Directory of residents.

The inspectors reviewed the complaints policy and found that it was in line with the regulations. One complaint remained open and had not been fully resolved on the day of the inspection. However, information was provided to inspectors following the inspection to show that communication had been issued to the complainant on the

actions taken, and the updated progress of the complaint, in line with the registered provider's policy on managing complaints.

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

The inspectors found that the registered provider had not ensured that applications were submitted to the Office of the Chief Inspector in line with Section 52 of the Health Act, where the registered provider wishes to vary a condition of registration attached by the Chief Inspector under Section 51 of the Act. This was evidenced by changes to the registered floor plan of the centre as follows:

- On Orchard unit, the two resident/visitors' rooms had been repurposed as activities stores, and were not accessible to residents or visitors.

Judgment: Not compliant

### Regulation 15: Staffing

The staff and skill mix was appropriate to the number and needs of residents, with the exception of ensuring that all residents had access to meaningful activities. This was evidenced by the following:

- An activities coordinator was re-allocated to the Djouce unit on the morning of the inspection. Inspectors were told that this was to cover the unexpected shortage of HCA staff, and was a short-term measure until agency staff arrived. Inspectors were told that this was a frequent occurrence.
- The rosters reviewed by the inspectors showed that on three occasions, only one member of staff was allocated responsibility to provide activities to the 89 residents in the main building. This meant that there was an insufficient number of activities staff to provide one-to-one activities and meet the social care needs of the residents on these occasions. This was evident on the day of inspection.

Judgment: Substantially compliant

### Regulation 19: Directory of residents

The directory of residents required review to ensure that the information specified in Schedule 3 was correctly documented for each resident. For example:

- Five residents did not have their date of birth recorded.

- One resident did not have a next of kin documented.
- Many records stated a resident was transferred from 'other', 'other nursing home' or 'Leopardstown Park Hospital', and did not specifically identify the name and address of the authority or organisation which arranged the admission of the resident to the designated centre.

This is a repeat finding

Judgment: Not compliant

## Regulation 23: Governance and management

The registered provider had not ensured there were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose, with the registered provider committing to 4 whole time equivalent (WTE) activities coordinators to provide activities. However, on the day of the inspection there were only 3.2 WTE activities co-ordinators employed, with these post holders redeployed if there was a shortage of HCA's to deliver direct care to residents. This further reduced the measures in place to ensure that residents had access to meaningful activities.

The management systems in place required review to ensure that the service provided was consistent and effectively monitored. This was evidenced by:

- Meetings and audits conducted did not always have documented aligned action plans, resulting in issues identified not being addressed in a timely and appropriate manner. For example:
  - A falls report for January to April 2025 identified three time frames each day when falls were most frequent. There was no documented evidence that an action plan had been implemented to investigate the reasons behind this, and to identify measures that could mitigate the risk of falls during these times.
  - Residents' meetings since July 2024 repeatedly documented requests for more activities, particularly at the weekends and evenings. No action plan had been implemented to address this, and residents had the same concerns on the day of the inspection.
- The oversight of maintenance issues required strengthening to ensure that issues were identified and addressed in a timely and appropriate manner.

A number of areas the registered provider had committed to addressing in the compliance plan from the inspection in January had not been completed within the agreed time frame. For example:

- An incomplete directory of residents was found on this inspection.
- The registered provider had committed to displaying fire evacuation maps throughout the centre. These were not in place on the day of the inspection.

- The registered provider had committed to completing a fire safety risk assessment to ensure all fire safety precautions were being implemented. This was not conducted, meaning potential fire safety risks had not been identified and mitigated.
- Maintenance issues remained outstanding.
- Smoking was not contained to designated smoking areas.

Judgment: Not compliant

### Regulation 31: Notification of incidents

The person in charge had failed to notify the Office of the Chief Inspector of all incidents as set out in paragraphs 7 (1)(a) to (i) of Schedule 4, within the required time frame of 2 working days of occurrence.

- Two safeguarding notifications had been submitted six days late.
- One safeguarding notification had been submitted five days late.

Judgment: Not compliant

### Regulation 34: Complaints procedure

The registered provider had a complaints procedure in place which was in line with the regulations. Complaints were seen to be handled according to the procedure, with written communication on the status of the complaint being provided to the complainant.

Judgment: Compliant

## Quality and safety

Overall, inspectors found that the quality and safety of care provided to residents was good. Nonetheless, there were areas which were impacted by the governance and management systems in place to identify improvements required under Regulation 17: Premises, Regulation 28: Fire precautions, and Regulation 9: Residents' rights.

Inspectors reviewed a sample of residents' care plans including responsive behaviour, communication, and occupation and recreation care plans. Overall, care

plans were found to be person-centred and sufficiently detailed to guide staff in providing good quality, safe care which was tailored to residents' individual needs and preferences. However, not all care plans reviewed were found to have been developed within 48 hours of the residents' admission to the centre, as is required by the regulations. This is discussed further under Regulation 5: Individual assessment and care planning.

The registered provider had ensured that the residents' environment was, in so far as possible, free from the use of restraint. There were procedures in place for the use of restrictive practices which were in line with national policy on the use of restraints. Inspectors reviewed a sample of residents' records. These records demonstrated that restraints were only in place following completion of a comprehensive risk assessment and residents, or their families if appropriate, had consented to the use of the restraint. However, the person in charge had not ensured that all staff had received training in managing and responding to challenging behaviours. This is discussed further under Regulation 7: Managing behaviour that is challenging.

Inspectors observed residents receiving visitors on the day of inspection. Residents told inspectors that there was no restrictions on visiting in the centre and that residents could choose where they received their visitors. Some residents told inspectors they liked to receive visitors in their bedrooms, whilst others received visitors in the designated visitors' rooms or other communal spaces, depending on their preference on the day. Visitors spoken with said they were made to feel welcome, and communication from staff was very good. However, not all units were found to provide private visiting spaces for residents, and on one of the units, the two visitors' rooms were being used as storage spaces. The inspectors reviewed the visitors' policy and found that the policy on visiting during an outbreak of Covid 19 required review with regards to the limitation of visitors, and the review period of two weeks. The arrangements for residents to receive nominated support persons also required clarification. These findings are discussed further under Regulation 11: Visits.

The inspectors walked around all areas of the centre and found that while the centre was mostly clean and well presented, there were areas of improvement required. Some findings from the last inspection had been remedied, such as areas of damp in the laundry and paintwork in the administrative block. However, the inspectors saw damaged floors, skirting boards and ceilings, which were findings from the previous inspection. Some communal rooms such as visitors' rooms, dining rooms and toilets were without call-bells, or had call-bells that were not fully functional. Each unit had store, sluice and clinical rooms and these were kept locked and clean. Residents' bedrooms were seen to be clean and tidy, with many personalised with residents' own belongings. Residents said that they had adequate space for their belongings.

The registered provider had made improvements in fire safety since the last inspection. There was now an appropriate smoking area for the Clevis unit, and the exit routes, pathways and lighting in the unit were all safe for use. However, an updated fire safety risk assessment had not been conducted since 2022, despite significant structural changes having been completed in the interim period. The

courtyard in the Djouce unit, while signed as a no-smoking area, was seen to be used as a smoking area without appropriate fire safety precautions. The inspectors saw a schedule of fire drills and found that some had not been completed correctly, and issues which arose during the drills had not been addressed.

The residents in the Clevis unit enjoyed access to a full and varied schedule of activities. However, due to the number of residents and the layout of the centre within the main building, it was not possible for the activities staff to cater to the needs of all the residents. This meant that not all residents enjoyed an equal amount and variety of activities. Leopardstown Park Hospital recently had become a non-smoking campus, and the registered provider had relocated smoking areas to promote this ethos. However, residents on the Djouce unit told inspectors that the new smoking area for their unit was a considerable distance away, making it difficult for them to access, and reliant on staff to assist them if they have mobility issues. This will be discussed further under Regulation 9: Residents' rights.

## Regulation 11: Visits

Not all units in the centre had suitable private areas available for residents to receive visitors. This was evidenced by the following findings:

- There was no private visitors' areas on the Djouce or Orchard units.
- On the Orchard unit, inspectors found that the two visitors' rooms as per the registered floor plans had been repurposed as storage spaces, and signage had been placed outside allocating them for 'activities'.

The visitors' policy required review to ensure that residents and visitors were aware of the arrangements to receive a nominated support person, and that visiting restrictions were in place for the shortest period possible.

Judgment: Substantially compliant

## Regulation 17: Premises

Not all areas of the premises conformed to the matters set out in Schedule 6. This was evidenced by:

- Damaged ceilings, walls and skirting in the Djouce unit, and damaged walls in the Avoca unit. This did not support effective cleaning.
- Damaged flooring in the visitors' room in the Glencree unit.
- Missing or damaged call-bells in communal rooms, which posed a risk to residents using those rooms, should they need assistance.

- Inadequate furniture in the sitting areas in the Glencree and Djouce units. This does not support a homely environment.

Judgment: Substantially compliant

### Regulation 26: Risk management

The risk management policy did not include the six specified risks as required by the regulations. This is a repeat finding.

Judgment: Not compliant

### Regulation 28: Fire precautions

While improvements had been made to address fire safety concerns, further action was required to ensure that staff had received suitable training in fire prevention and emergency procedures and were aware of the procedures to be followed in the case of fire. This was evidenced by:

- Fire drills were not conducted in a manner to ensure staff were familiar with the evacuation procedure on their unit, and that issues identified during a fire drill were actioned appropriately. For example:
  - Staff were unable to locate a ski sledge during one drill and this was not addressed in the learnings section of the report.
  - Staff told inspectors that they did not feel there were adequate fire drills conducted in their units.

Adequate arrangements for reviewing fire precautions had not been put in place. The registered provider had committed to arranging an updated fire safety risk assessment to be completed. This was not complete on the day of the inspection, and there was no scheduled date for this to be completed.

While there were a number of escape routes within the designated centre, not all means of escape were maintained and adequate to ensure the safe evacuation of residents. The escape route from the Djouce unit was used as a smoking area for residents in that unit. This was a repeat finding from the last inspection.

Judgment: Not compliant

### Regulation 5: Individual assessment and care plan

The person in charge had arranged a comprehensive assessment for residents on admission to the centre. However, not all care plans reviewed had been prepared within 48 hours of admission. For example:

- One resident's continence care plan had not been developed until 11 days after they had been admitted to the centre.
- One resident's nutrition care plan had not been developed until 5 days after they had been admitted to the centre.

Judgment: Substantially compliant

### Regulation 7: Managing behaviour that is challenging

The person in charge had not ensured that all staff had up to date knowledge and skills appropriate to their role, to respond to and manage behaviour that is challenging. This was evidenced by 17% of staff with direct involvement in the care of residents not completing, or not updating, their training in responsive behaviours.

Judgment: Substantially compliant

### Regulation 9: Residents' rights

Not all residents had equal access to facilities for occupation and recreation. This was evidenced by:

- Residents who lived in the main building did not have the same access to an appropriate smoking area as the residents who lived in the Clevis unit.

Residents' access to meaningful and engaging activities remained outstanding. Not all residents had the same opportunities to participate in activities in accordance with their interests and capacities. This was evidenced by:

- Residents who lived in the Clevis unit had access to a schedule of activities daily and were encouraged to participate in activities of interest to them. Residents who lived in the units in the main building did not have the same access to activities.
- There was no evidence that activities were taking place once the activities co-ordinator was off duty, other than in the Clevis unit. This was evidenced by the inspectors' review of the activities schedule, and the residents and staff telling the inspectors that there was no scheduled activities other than the 'activity of the day'.
- Residents did not have access to activities at weekends other than in the Clevis unit.

This is a repeat finding.

The visitors' rooms were not set up to facilitate residents to receive visitors in a private and appropriate environment.

Residents' concerns raised during residents' meetings were not addressed, which did not support residents to participate in the organisation of the centre.

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
<b>Capacity and capability</b>	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Leopardstown Park Hospital OSV-0000667

Inspection ID: MON-0046254

Date of inspection: 13/10/2025

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

## Section 1

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

### Compliance plan provider's response:

Regulation Heading	Judgment
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
<p>Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration:</p> <p>Situation: Inspectors identified that the registered provider had not submitted applications to the Office of the Chief Inspector in line with Section 52 of the Health Act when varying a condition of registration. This was evidenced by changes to the registered floor plan, where two resident/visitor rooms in the Orchard unit had been repurposed as activity stores and were no longer accessible to residents or visitors.</p> <p>Task</p> <p>The registered provider is required to ensure full and sustained compliance with Regulation 7 by:</p> <ol style="list-style-type: none"> <li>1. Ensuring that all variations to conditions of registration, including changes to room function or floor plans, are formally submitted to the Office of the Chief Inspector in advance and in line with Section 52 of the Health Act 2007.</li> <li>2. Ensuring that room designation, use, and signage accurately reflect the approved and registered purpose of each space.</li> <li>3. Strengthening governance, oversight, and staff awareness to prevent any recurrence of unapproved changes to registered premises.</li> </ol> <p>Action</p> <p>The following corrective and preventive actions have been implemented and/or are in progress:</p> <ol style="list-style-type: none"> <li>1. Immediate Review of Orchard Unit <ul style="list-style-type: none"> <li>• A full review of the Orchard Unit accommodation and room usage was completed by the senior management team to confirm alignment between registered floor plans, current room use, and signage.</li> <li>• This review identified that the issue related to incorrect room signage and the misinterpretation of room designation.</li> </ul> </li> </ol>	

## 2. Correction of Room Signage

- New, accurate name plates have been ordered and will be installed to clearly reflect the correct and registered designation of each room within the Orchard Unit.
- This ensures transparency and clarity for residents, visitors, staff, and inspectors.

## 3. Formal Governance Protocol for Registration Changes

- A formal Registration Variation Protocol has been developed and implemented.
- This protocol requires that any proposed change to room use, accommodation, or floor plans is:

- Identified in advance,
- Escalated to the Registered Provider Representative,
- Assessed for regulatory impact, and
- Submitted to the Office of the Chief Inspector under Section 52 prior to implementation.

## 4. Strengthened Management Oversight

- Ongoing oversight responsibility has been assigned to the CNM and ADON, who are required to:
  - Monitor room usage within their areas of responsibility,
  - Promptly report any proposed or emerging changes to the Registered Provider, and
  - Ensure no changes occur without regulatory approval.
- This oversight is supported through regular unit walkabouts and governance reporting structures.

## 5. Staff Awareness and Accountability

- Senior nursing and management staff have been reminded of their responsibilities under Regulation 7 and Section 52 of the Health Act.
- This includes clarification that no changes to registered accommodation or room function may occur without formal approval.

### Result / Outcome

- Room signage will accurately reflect the approved and registered purpose of each space, ensuring clarity and transparency for residents, visitors, and inspectors.
- All future applications for the variation or removal of conditions of registration will be submitted in full compliance with Regulation 7 and Section 52 of the Health Act 2007, prior to any change being implemented.
- Governance and oversight arrangements have been strengthened to provide ongoing assurance that the designated centre operates strictly within its registered conditions.
- These actions ensure sustained regulatory compliance and prevent any future misinterpretation, oversight, or non-compliance in relation to changes to the registered premises.

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Regulation 15: Staffing

Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

Situation: Inspectors identified that while staff and skill mix were generally appropriate, there were concerns about ensuring all residents had access to meaningful activities. Specifically, an activities coordinator was reported as being reallocated to cover HCA

duties, and rosters showed occasions where only one staff member was responsible for activities for 89 residents.

#### Task

To achieve and sustain full compliance with Regulation 15, the registered provider will:

1. Ensure consistent, reliable, and resident-centred activity provision across all units.
2. Protect the integrity of the activities staffing role, ensuring activity staff are not redeployed from their designated duties except in clearly defined and documented emergency situations.
3. Strengthen governance, oversight, and monitoring of activity staffing, rostering, and delivery to provide ongoing regulatory assurance.

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#### Action

The following actions have been implemented and embedded:

##### 1. Review and Clarification of Activity Staffing

- A comprehensive review of activity staffing levels, rostering, and deployment was completed.
- For accuracy and assurance, the registered provider clarifies that activity staff were not redeployed to HCA duties on the day of inspection. The staff member referenced was engaged in scheduled one-to-one resident activity work, which forms part of their defined role and responsibilities.
- This clarification has been communicated through management and governance structures.

##### 2. Protected Activity Staffing Arrangements

- A structured system has been implemented to ensure that activity facilitators remain allocated to their scheduled activity duties.
- Redeployment of activity staff may only occur in exceptional, documented emergency circumstances, and must be:
  - Approved in advance by the CNM or ADON, and
  - Recorded with clear rationale and duration.
- This measure ensures continuity of activity provision while maintaining safe clinical staffing.

##### 3. Revised Rostering and Escalation Framework

- A revised activity rota has been introduced to ensure appropriate coverage across all units and to minimise reliance on single-staff activity provision.
- A formal escalation and redeployment protocol has been implemented to manage unplanned absences or service pressures without compromising residents' access to activities.

##### 4. Multidisciplinary and Volunteer Support Model

- Activity provision continues to be supported through a multidisciplinary approach, including:
  - Health Care Assistants,
  - Occupational Therapy,
  - Physiotherapy,
  - Chaplaincy, and
  - Volunteer services.
- This integrated model operates under the oversight of the ADON, ensuring coordinated, resident-focused delivery while maintaining clear accountability for activity staffing.

##### 5. Governance, Monitoring, and Audit

- Monthly audits of activity provision are now in place, examining:
  - Availability and range of activities,
  - Weekend and evening provision,
  - Resident participation and engagement, and
  - Staffing coverage and redeployment occurrences.
- Audit findings are reviewed through established governance structures, with actions identified and tracked where required.

Result / Outcome

- Residents have consistent and equitable access to meaningful activities across all units, aligned with assessed needs and preferences.
- Activity staff remain dedicated to their designated roles, with redeployment occurring only in exceptional, documented circumstances and under senior management approval.
- Revised rosters, escalation pathways, and protocols ensure the continuity, reliability, and sustainability of activity provision.
- Ongoing governance oversight and monthly audits provide assurance of sustained compliance with Regulation 15 and support continuous quality improvement.

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Regulation 19: Directory of residents	Not Compliant
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Outline how you are going to come into compliance with Regulation 19: Directory of residents:

Situation: Inspectors found that the Directory of Residents did not fully comply with Schedule 3 requirements. Missing information included dates of birth for five residents, absence of next of kin details for one resident, and incomplete documentation of admission sources. This was noted as a repeat finding.

Task

The registered provider is required to ensure that the Directory of Residents is:

1. Fully complete, accurate, and contemporaneously maintained in line with Schedule 3 requirements.
2. Subject to strengthened validation, oversight, and governance arrangements to prevent recurrence.
3. Maintained through clear accountability and staff awareness of documentation standards and regulatory obligations.

Action

The following corrective and preventive actions have been implemented:

1. Immediate Rectification and Full Review
  - A full review of the Directory of Residents was completed immediately following the inspection.
  - All missing or incomplete data fields, including dates of birth, next of kin / nominated representative details, and source of admission, have been fully updated and verified.
2. Root Cause Clarification
  - For assurance and clarity, the identified gaps did not arise from an absence of policy or process, but from isolated ICT recording omissions.

- These gaps have now been corrected, and additional safeguards have been introduced to strengthen reliability.

### 3. Daily Validation and Sign-Off Process

- A daily validation process has been implemented, requiring CNM sign-off to confirm that all mandatory Schedule 3 information is complete and accurate.

- This includes verification of:

- Date of birth,
- Nominated representative / next of kin details, and
- Source of admission.

- This process ensures that omissions are identified and corrected at the earliest opportunity.

### 4. Monthly Governance Audit

- A formal monthly audit of the Directory of Residents has been introduced as part of the governance framework.

- Audits assess:

- Completeness and accuracy of all Schedule 3 data fields,
- Consistency between admission documentation and the Directory, and
- Any emerging trends or anomalies.

- Audit outcomes are reviewed at governance level, with corrective actions tracked where required.

### 5. Staff Training and Accountability

- Documentation standards and regulatory requirements under Regulation 19 and Schedule 3 have been reinforced with relevant staff.

- Clear accountability has been reiterated, ensuring staff understand their role in maintaining accurate and complete resident records.

#### Result / Outcome

- All resident entries within the Directory of Residents now contain complete and accurate information, fully aligned with Schedule 3 requirements.
- Daily CNM validation provides real-time assurance and prevents recurrence of documentation gaps.
- Monthly governance audits ensure sustained oversight, early detection of anomalies, and continuous compliance.
- The actions implemented address the repeat finding, strengthen internal controls, and ensure the Directory of Residents is fully compliant with Regulation 19 on an ongoing basis.

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Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

Situation:

Inspectors found that governance and management systems required strengthening.

Concerns included insufficient activity staffing (3.2 WTE instead of 4 WTE), redeployment

of activity coordinators to cover HCA shortages, lack of documented action plans following audits and meetings, incomplete directory of residents, absence of fire evacuation maps, lack of fire safety risk assessment, unresolved maintenance issues, and smoking outside designated areas.

#### Task

To achieve and sustain compliance with Regulation 23, the registered provider will:

1. Ensure sufficient resources, including staffing and infrastructure, are in place to deliver care in accordance with the Statement of Purpose.
2. Strengthen governance, accountability, and escalation systems to ensure timely action, monitoring, and closure of identified risks and deficits.
3. Address and close all outstanding actions from previous compliance plans, ensuring sustained improvement rather than episodic responses.

#### Action

The following corrective and preventive actions have been implemented and embedded within the governance framework:

##### 1. Governance, Reporting, and Accountability

- All audit reports, inspection findings, and governance reviews are now formally circulated to the relevant committee(s) with clearly defined proposed actions, responsible persons, and timelines.
- Committee members are required to provide concurrence or amendments via email, ensuring prompt decision-making and documented accountability.
- A central action-tracking mechanism is now in place to monitor progress and ensure closure of actions within agreed timeframes.

##### 2. Activities Provision and Staffing Resources

- Activity staffing has been reviewed in the context of the Statement of Purpose and residents' assessed needs.
- Each unit is now equipped with a dedicated activities folder, outlining structured weekday, evening, and weekend programmes.
- Activities beyond core hours are supported through initiatives including:
  - Rosary recitation,
  - Gentle exercise programmes,
  - Visits from Order of Malta cadets,
  - Chaplaincy-led and volunteer-supported engagements.
- Activity staff redeployment is now restricted to exceptional, documented emergencies only, with prior approval from the CNM/ADON and oversight by senior management.

##### 3. Maintenance Oversight and Environmental Safety

- A QR-based maintenance reporting system has been implemented, allowing staff to report defects in real time.
- All maintenance requests are automatically escalated to the Person in Charge (PIC), strengthening oversight and ensuring timely prioritisation and resolution.
- Maintenance issues are reviewed on an ongoing basis through governance structures to ensure risks are mitigated promptly.

##### 4. Fire Safety Governance

- Fire evacuation maps are currently being updated and will be prominently displayed throughout the hospital once finalised.
- The Annual Fire Safety Certification has been scheduled for 19 November and will be completed by a competent person from FCC, ensuring compliance with regulatory and legislative fire safety requirements.
- Fire safety oversight has been strengthened through clearer accountability and

monitoring arrangements.

#### 5. Smoking Control and Policy Compliance

- Designated smoking areas have been clearly identified, communicated, and reinforced with both residents and staff.
- The area referenced during inspection is not a designated smoking area, and formal reminders have been issued to ensure compliance.
- Leopardstown Park Hospital operates as a smoke-free and e-cigarette-free campus, with provision made for the small number of residents who choose to smoke, alongside:
  - Clear risk management arrangements, and
  - Access to smoking cessation supports as part of a broader health-promotion strategy.

#### 6. Closure of Historical Compliance Actions

- A review of previous compliance plans has been completed to ensure all outstanding actions are identified, addressed, and formally closed.
- These actions are now monitored through governance structures to ensure sustained compliance rather than short-term remediation.

#### Result / Outcome

- Residents receive care supported by adequate staffing, structured activity provision, and safe environments, in line with the Statement of Purpose.
- Governance systems now ensure clear accountability, documented action plans, and timely follow-up on audits, inspections, and identified risks.
- Maintenance and fire safety risks are identified, escalated, and mitigated in a timely and structured manner.
- Smoking is confined to designated areas, with clear policy direction and cessation supports in place.
- Overall, governance and management arrangements now provide effective oversight, assurance, and continuous improvement, ensuring sustained compliance with Regulation 23.

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Regulation 31: Notification of incidents

Not Compliant

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

Situation: Inspectors found that the person in charge had failed to notify the Office of the Chief Inspector of incidents as required under Schedule 4, within the mandated two working days. Specifically, two safeguarding notifications were submitted six days late, and one safeguarding notification was submitted five days late.

#### Task

To achieve and sustain full compliance with Regulation 31, the registered provider will:

1. Ensure that all notifiable incidents, including safeguarding concerns, are submitted to HIQA within two working days as required under Schedule 4.
2. Strengthen staff understanding, accountability, and confidence in identifying, escalating, and reporting safeguarding concerns without delay.
3. Implement monitoring and assurance mechanisms to prevent recurrence of delayed notifications.

## Action

The following corrective and preventive actions have been implemented:

### 1. Explanation and Learning from Delayed Notifications

- The delayed notifications referenced in the draft inspection report were fully explained to the Authority at the time of inspection:

- One notification arose from a general complaint initially submitted to the Complaints Officer, during which a peer-to-peer abusive interaction was identified as a safeguarding concern during the investigation process.

- A second delay occurred due to a staff member taking time to reflect on the situation before formally escalating the concern.

- While these circumstances were contextual, learning has been taken to ensure earlier escalation and parallel notification in future cases.

### 2. Reinforced Safeguarding Guidance

- Written guidance has been circulated to all Clinical Nurse Managers (CNMs) outlining:

- The requirement to assess incidents involving violence, aggression, or abuse for potential safeguarding implications, and

- The obligation to ensure immediate escalation to the Leopardstown Park Hospital Safeguarding Team where concerns are identified.

- The guidance explicitly reinforces the requirement to notify HIQA within two working days, irrespective of parallel internal investigations.

### 3. Strengthened Accountability and Oversight

- A formal monitoring system has been introduced whereby the Assistant Director of Nursing (ADON):

- Reviews safeguarding logs weekly, and

- Confirms that all notifiable incidents have been submitted to HIQA within the required timeframe.

- Any delays or anomalies are escalated immediately to the PIC for action.

### 4. Staff Training and Awareness

- Targeted staff training sessions have been scheduled to:

- Reinforce awareness of safeguarding thresholds,

- Clarify notification timelines under Regulation 31 and Schedule 4, and

- Strengthen confidence in early escalation and reporting.

- Training attendance and learning outcomes are monitored through governance structures.

## Result / Outcome

- All incidents are now promptly assessed for safeguarding implications at the earliest point of identification.

- HIQA notifications are submitted within the mandated two working days, in full compliance with Regulation 31 and Schedule 4.

- CNMs and the Safeguarding Team have clear accountability for timely escalation and reporting, supported by weekly oversight from the ADON.

- These strengthened systems provide assurance of sustained compliance and demonstrate learning and improvement following the inspection findings.

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Regulation 11: Visits	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 11: Visits:  Situation: Inspectors found that not all units had suitable private areas available for residents to receive visitors. Specifically, the Djouce and Orchard units lacked designated private visitor spaces, and on Orchard, the two visitors' rooms had been repurposed as storage areas with signage indicating "activities." The visitors' policy also required review to ensure clarity on arrangements for nominated support persons and visiting restrictions.</p> <p>Task  To achieve and sustain compliance with Regulation 11, the registered provider will:</p> <ol style="list-style-type: none"> <li>1. Ensure residents have access to suitable, private areas to receive visitors across all units.</li> <li>2. Ensure visitor rooms are correctly designated, accessible, and clearly signposted in line with registered floor plans.</li> <li>3. Review and update the Visitors' Policy to ensure residents and visitors are fully informed of visiting arrangements, nominated support persons, and the limited circumstances in which restrictions may apply.</li> </ol> <p>Action  The following corrective and preventive actions have been implemented:</p> <ol style="list-style-type: none"> <li>1. Orchard Unit – Visitor Room Designation <ul style="list-style-type: none"> <li>• A review of the Orchard Unit identified that the issue related to incorrect signage, rather than a permanent removal of visitor space.</li> <li>• New nameplates have been ordered and will be installed to clearly and accurately reflect the rooms' designated purpose as visitor rooms, in line with the registered floor plan.</li> <li>• This corrective action ensures clarity for residents, visitors, and inspectors and prevents future misinterpretation.</li> </ul> </li> <li>2. Djouce Unit – Access to Private Visiting Areas <ul style="list-style-type: none"> <li>• Residents of the Djouce Unit are facilitated to receive visitors in the Library / Coffee Dock, located in close proximity to the unit, providing a suitable and private environment.</li> <li>• In addition, the external courtyard is available for resident use, offering an alternative private visiting space where appropriate and in line with residents' preferences.</li> </ul> </li> <li>3. Visitors' Policy Review <ul style="list-style-type: none"> <li>• The Visitors' Policy is currently under review to: <ul style="list-style-type: none"> <li>• Clearly outline residents' rights to receive visitors and nominated support persons,</li> <li>• Provide clarity on visiting arrangements across units, and</li> <li>• Emphasise that any visiting restrictions are applied only where necessary, are proportionate, and are for the shortest period possible.</li> </ul> </li> <li>• Once finalised, the revised policy will be communicated to residents, families, and staff.</li> </ul> </li> <li>4. Governance and Oversight <ul style="list-style-type: none"> <li>• Ongoing oversight has been assigned to the CNM and ADON, who will: <ul style="list-style-type: none"> <li>• Monitor the availability and appropriate use of visitor rooms,</li> <li>• Ensure signage remains accurate and aligned with the registered floor plan, and</li> <li>• Escalate any issues requiring corrective action.</li> </ul> </li> <li>• This monitoring forms part of routine governance walkabouts and reviews.</li> </ul> </li> </ol> <p>Result / Outcome</p> <ul style="list-style-type: none"> <li>• Residents in both the Orchard and Djouce Units have access to suitable, private areas to receive visitors in line with Regulation 11.</li> </ul>	

- Visitor rooms are correctly designated and clearly signposted, ensuring transparency and regulatory compliance.
- The revised Visitors' Policy provides clear, accessible guidance to residents and visitors, reinforcing residents' rights to visits and ensuring any restrictions are minimal and justified.
- Strengthened governance oversight ensures sustained compliance with Regulation 11 and continued protection of residents' rights.

Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Situation: Inspectors found that not all areas of the premises conformed to Schedule 6 requirements. Issues included damaged ceilings, walls, and skirting in the Djouce and Avoca units; damaged flooring in the Glenree visitors' room; missing or damaged call-bells in communal rooms; and inadequate furniture in sitting areas, which did not support a homely environment.

Task

To achieve and sustain compliance with Regulation 17, the registered provider will:

1. Ensure all areas of the premises are maintained in good structural repair and are suitable for effective cleaning and infection prevention and control.
2. Ensure call-bell systems are fully functional and accessible in all communal areas.
3. Provide adequate, comfortable, and appropriate furniture to support residents' comfort, dignity, and social interaction.
4. Enhance the ambience and homeliness of shared spaces to support person-centred care and resident wellbeing.

Action

The following corrective and preventive actions have been implemented or are in progress:

1. Ceilings, Walls, and Skirting: Djouce and Avoca Units

- All identified areas of damage have been assessed and repairs completed, ensuring surfaces are smooth, intact, and suitable for effective cleaning and maintenance.
- It is recognised that in a large, high-activity campus such as Leopardstown Park Hospital, routine wear and tear is inevitable. To strengthen oversight:
  - A QR-code-based fault reporting system has been introduced.
  - This system allows staff, residents, and visitors to report maintenance issues easily.
  - Reports are sent directly to the Maintenance Service, monitored centrally, and the reporter receives feedback on progress and resolution.

2. Flooring: Glenree Visitors' Room

- The damaged flooring has been formally addressed through the procurement process.
- Tenders were sought, a contractor has been appointed, and
- Remedial works are scheduled for completion within two weeks, ensuring the area is safe, accessible, and suitable for visitor use.

3. Communal Call-Bell Systems

- A full inspection of call-bell systems in communal areas has been completed, and all call-bells are now confirmed to be fully operational.
- To ensure sustained compliance:
  - Monthly call-bell audits have been introduced, and
  - Any faults identified are escalated and rectified without delay.

4. Furniture in Sitting Areas and TV Rooms

- A comprehensive review of seating and furniture needs has been undertaken.
- Additional furniture has been ordered and will be installed in the coming days, including:
  - Armchairs for TV and sitting areas, ensuring residents, visitors, and family members have seating options beyond wheelchairs or personal chairs, and
  - Sofas and soft seating for family rooms and visitors' areas, creating welcoming and comfortable spaces for meaningful interaction.
- Furniture selection has been:
  - Guided by resident comfort and individual needs,
  - Fully compliant with Infection Prevention and Control (IPC) requirements, and
  - Identified collaboratively by Physiotherapy, Occupational Therapy, Nursing, and Care teams, in consultation with residents.

5. Room Ambience and Homeliness Project

- A phased ambience enhancement project has commenced to further support a homely, person-centred environment in shared spaces.
- This includes:
  - Feature walls with framed, resident-chosen photographs (family, personal milestones, meaningful moments), and
  - Deep-set memorabilia box frames allowing residents to display personal items safely.
- These enhancements are designed to:
  - Support residents' identity and emotional wellbeing,
  - Maintain full IPC compliance, and
  - Be appropriate for cohort-style shared living environments.

Result / Outcome

- All identified areas of damage have been repaired or scheduled for completion, ensuring safety, durability, and effective cleaning.
- Call-bell systems are fully functional, with monthly audits providing ongoing assurance.
- Sitting areas and visitors' rooms are furnished with comfortable, inclusive seating, supporting social engagement, relaxation, and dignity.
- The ambience enhancement project promotes a homely, person-centred environment, positively impacting resident wellbeing.
- Collectively, these actions ensure sustained compliance with Regulation 17 and provide a safe, welcoming, and supportive environment for residents, families, and visitors.

Regulation 26: Risk management	Not Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management:

## Situation

- Inspectors identified that the existing risk management policy did not include the six specified risks required under Regulation 26.
- This was a repeat finding, leading to a judgment of Not compliant.
- The organization must demonstrate corrective action and sustained compliance.

## Task

To achieve and sustain compliance with Regulation 26, the registered provider will:

1. Ensure the Risk Management Policy is fully aligned with Regulation 26 and explicitly incorporates the six specified risks.
2. Secure appropriate governance approval for the revised policy and embed it across operational practice.
3. Provide clear assurance mechanisms to demonstrate effective implementation, monitoring, and sustained compliance, preventing any recurrence of this finding.

## Action

The following corrective and preventive actions have been completed and implemented:

### 1. Policy Review and Update

- A comprehensive review of the Risk Management Policy was undertaken in conjunction with the hospital's independent Risk Advisor, ensuring alignment with legislative and regulatory requirements.
- The revised policy has been formally approved by the Audit and Risk Board Committee and the Hospital Board, demonstrating senior leadership oversight and accountability.

### 2. Integration of the Six Specified Risks

The revised Risk Management Policy now explicitly includes and addresses the six risks mandated under Regulation 26:

1. Unexplained absence of a resident
2. Accidental injury to residents, visitors, or staff
3. Aggression and violence
4. Self-harm
5. Infection prevention and control
6. Fire safety

Each risk is clearly documented within the policy, with associated controls, escalation pathways, and mitigation measures outlined.

### 3. Risk Appetite and Governance Alignment

- The Risk Appetite Statement has been updated to clearly articulate the organisation's tolerance levels, risk thresholds, and mitigation strategies.
- This ensures consistency between operational decision-making, governance oversight, and regulatory expectations.

### 4. Implementation and Staff Awareness

- An implementation plan has been developed to embed the revised policy into daily practice.

- Targeted staff training sessions have been scheduled to:

- Reinforce awareness of the six specified risks,
- Clarify reporting and escalation responsibilities, and
- Ensure consistent application of the policy across all departments.

### 5. Monitoring, Audit, and Assurance

- A quarterly audit cycle has been established to:
  - Verify compliance with the revised Risk Management Policy,
  - Assess the effectiveness of controls in place for each of the six specified risks, and
  - Identify any emerging gaps or trends requiring action.

- Audit findings are reviewed through governance structures, with actions tracked to completion.

Result / Outcome

- The revised Risk Management Policy now fully complies with Regulation 26, addressing the repeat finding.
- Clear documentation of the six specified risks ensures transparency, accountability, and regulatory alignment.
- Staff are being trained to implement the policy consistently, reducing organisational risk exposure.
- Ongoing monitoring and quarterly audits provide robust assurance and prevent recurrence of non-compliance.
- The organisation is positioned to demonstrate sustained compliance with Regulation 26 at the next inspection.

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Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:  
Situation

- Inspectors found that while improvements had been made, fire safety arrangements were still inadequate.
- Staff were not fully trained in fire prevention and emergency procedures.
- Fire drills were inconsistent, issues identified were not actioned, and escape routes were obstructed (e.g., Djouce unit used as a smoking area).
- A fire safety risk assessment had not been completed or scheduled at the time of inspection.
- This was a repeat finding, resulting in a judgment of Not compliant.

Task

- To achieve and sustain full compliance with Regulation 28, the registered provider will:
1. Ensure all staff receive appropriate fire safety training and are competent in fire prevention, evacuation, and emergency procedures.
  2. Implement a programme of regular, unit-specific fire drills, with documented learning and follow-up actions.
  3. Ensure evacuation equipment and escape routes are maintained, accessible, and fit for purpose at all times.
  4. Complete and schedule fire safety risk assessments and annual compliance declarations in line with legislative requirements.
  5. Embed a culture of fire safety awareness and accountability across the centre.

Action

- The following corrective and preventive actions have been implemented and embedded:
1. Fire Drills and Staff Training
    - Departmental fire drills are now conducted on a regular basis.
    - Bi-monthly fire drills, specific to each unit and department, have been formally scheduled and are already underway since the inspection.
    - Fire drills are tailored to individual units to ensure staff are familiar with:

- Local escape routes,
- Compartmentation arrangements, and
- Resident evacuation procedures relevant to their area.
- Issues identified during drills are:
  - Clearly documented,
  - Assigned to a responsible person, and
  - Addressed promptly through corrective actions.
- Fire safety trainers have been instructed to complete the actions and learning section of all drill and training reports to ensure accountability and follow-through.

## 2. Evacuation Equipment

- Ski sledges and ski sheets are in place across the centre and are:
  - Checked regularly for condition and accessibility, and
  - Included as standard components of fire safety training and drills.
- This ensures staff competence and confidence in the use of evacuation equipment during emergencies.

## 3. Fire Safety Risk Assessment and Certification

- A comprehensive fire safety risk assessment has now been completed, with control measures clearly identified and implemented where required.
- An Annual Fire Safety Compliance Declaration has been completed by an independent fire consultancy service, previously employed by the Authority, providing external assurance.
- Ongoing inspection and maintenance of fire detection, alarm, and suppression systems are carried out by a competent contractor, in line with legislative requirements.
- The annual certification and review process is scheduled and embedded into the governance calendar, including certification by FCC on 19 November 2025.

## 4. Escape Routes, Signage, and Oversight

- Clinical Nurse Managers (CNMs) have been assigned responsibility for routine checks to ensure all escape routes remain:
  - Clear,
  - Unobstructed, and
  - Appropriately signed.
- The escape route in the Djouce Unit is no longer designated or used as a smoking area; this has been formally reinforced with both staff and residents.
- Additional fire evacuation maps are being prominently displayed throughout the centre to support safe and efficient evacuation.

## Result / Outcome

- Staff are trained, competent, and confident in fire prevention, evacuation, and emergency response.
- Fire drills are regular, unit-specific, and supported by documented learning and prompt corrective action.
- Evacuation equipment is accessible, maintained, and embedded into training and drills.
- A completed fire safety risk assessment and annual compliance declaration provide formal assurance and ongoing review.
- Escape routes are clear, appropriately managed, and supported by visible signage and evacuation maps.
- These measures address the repeat finding and position the centre to demonstrate sustained compliance with Regulation 28 at the next inspection.

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Regulation 5: Individual assessment and care plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <p>Situation</p> <ul style="list-style-type: none"> <li>• Inspectors found that while comprehensive assessments were arranged on admission, care plans were not consistently prepared within the required 48 hours.</li> <li>• Examples included delays of 5 and 11 days in developing nutrition and continence care plans.</li> <li>• This resulted in a judgment of Substantially compliant, highlighting the need for stronger adherence and oversight.</li> </ul> <p>Task</p> <p>To achieve and sustain full compliance with Regulation 5, the registered provider will:</p> <ol style="list-style-type: none"> <li>1. Ensure that all residents have a complete, individualised care plan developed within 48 hours of admission, informed by assessed needs.</li> <li>2. Strengthen staff awareness, monitoring, and accountability to prevent delays in care planning.</li> <li>3. Embed compliance with Regulation 5 into routine practice, audit processes, governance oversight, and performance monitoring.</li> </ol> <p>Action</p> <p>The following corrective and preventive actions have been implemented:</p> <ol style="list-style-type: none"> <li>1. Staff Training and Awareness <ul style="list-style-type: none"> <li>• Targeted training has been delivered to all relevant staff, reinforcing: <ul style="list-style-type: none"> <li>• The regulatory requirement to develop care plans within 48 hours of admission, and</li> <li>• The importance of timely documentation to support safe, person-centred care.</li> </ul> </li> <li>• CNM 1/2/3 have been tasked with increased vigilance in monitoring care plan completion and providing immediate guidance and support where delays are identified.</li> </ul> </li> <li>2. Auditing and Oversight <ul style="list-style-type: none"> <li>• Clinical Nurse Managers now conduct regular audits of resident care plans to verify: <ul style="list-style-type: none"> <li>• Completeness,</li> <li>• Individualisation, and</li> <li>• Timeliness of development within the 48-hour requirement.</li> </ul> </li> <li>• Audit tools have been updated to specifically track care-plan timeliness, ensuring that any delays or omissions are promptly identified.</li> <li>• Where delays are identified, corrective action is taken without delay.</li> </ul> </li> <li>3. Monitoring, Governance, and Accountability <ul style="list-style-type: none"> <li>• Audit findings are reviewed at governance and management meetings to ensure: <ul style="list-style-type: none"> <li>• Clear accountability, and</li> <li>• Continuous quality improvement.</li> </ul> </li> <li>• Compliance with Regulation 5 has been incorporated as a Key Performance Indicator (KPI) on the Senior Management Team (SMT) agenda.</li> <li>• Staff receive structured feedback and additional support where required.</li> <li>• Any emerging or repeated non-compliance trends are escalated to senior management</li> </ul> </li> </ol>	

for immediate corrective action.

#### Result / Outcome

- All residents will have individualised care plans developed within 48 hours of admission, informed by the initial pre-admission assessment and ongoing clinical assessment.
- Staff are trained, informed, and clearly accountable for timely care planning.
- Regular audits and governance oversight provide assurance that delays are identified and corrected promptly.
- Continuous monitoring, feedback, and escalation mechanisms embed a culture of regulatory compliance and quality improvement.
- The centre is positioned to demonstrate full compliance with Regulation 5 at the next inspection.

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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:

#### Situation

- Inspectors found that 17% of staff directly involved in resident care had not completed or updated their training in responsive behaviours.
- This gap meant not all staff had the up-to-date knowledge and skills required to manage behaviour that is challenging.
- As a result, the centre was judged Substantially compliant rather than fully compliant.

#### Task

To achieve and sustain full compliance with Regulation 7, the registered provider will:

1. Ensure 100% of staff, both clinical and non-clinical, complete and maintain up-to-date training in managing behaviour that is challenging.
2. Establish a robust and sustainable system to prevent future lapses in training compliance.
3. Provide assurance that staff are competent, confident, and consistent in their responses, supporting resident safety, dignity, and wellbeing.

#### Action

The following corrective and preventive actions have been implemented:

##### 1. Training Delivery

- Revised training dates were established following the cancellation of the June sessions.
- Training sessions are currently underway this week, with a published schedule ensuring that all staff are included and facilitated to attend.
- Completion of the programme is mandatory for both clinical and non-clinical staff, reflecting the shared responsibility for supporting residents who experience responsive behaviours.

##### 2. Compliance Monitoring and Accountability

- Reminder notices have been issued to staff who had not yet completed the training.
- Training attendance is tracked centrally, with any non-compliance escalated to the relevant line manager for follow-up.

- CNM 1/2/3 have been tasked with monitoring completion rates and reporting progress on a weekly basis, ensuring timely oversight and intervention where required.

### 3. Sustainability and Governance Measures

- Training in managing behaviour that is challenging has been embedded into the induction programme for all new staff.
- Annual refresher training cycles have been scheduled to ensure skills and knowledge remain current.
- Training compliance data is reviewed through governance meetings, reinforcing accountability and continuous oversight.
- Staff who are unable to attend a scheduled session are automatically rebooked onto the next available training date to prevent gaps.

#### Result / Outcome

- All staff will have up-to-date training in managing behaviour that is challenging, ensuring full compliance with Regulation 7.
- Staff knowledge, confidence, and skill levels will be consistent across the centre, supporting safe, respectful, and person-centred care.
- Centralised monitoring and governance oversight provide assurance that future lapses in compliance are prevented.
- These measures position the centre to demonstrate full compliance with Regulation 7 at the next inspection.

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Regulation 9: Residents' rights	Not Compliant
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#### Outline how you are going to come into compliance with Regulation 9: Residents' rights: Situation

- Inspectors found that not all residents had equal access to facilities for recreation.
- Residents in the main building lacked access to appropriate smoking areas and did not have the same opportunities for meaningful activities compared to those in the Clevis unit.
- Activities were limited outside of the activities coordinator's hours, with little provision in evenings or weekends.
- Visitors' rooms were not set up to ensure privacy, and residents' concerns raised in meetings were not addressed.
- This was a repeat finding, resulting in a judgment of Not compliant.

#### Task

To achieve and sustain compliance with Regulation 9, the registered provider will:

1. Ensure equal access for all residents to facilities, activities, and recreation, regardless of unit location.
2. Provide appropriate smoking facilities, meaningful activities tailored to residents' interests and capacities, and private visitor spaces.
3. Establish robust systems to ensure residents' views are heard, acted upon, and fed back, supporting meaningful participation in the organisation of the centre.
4. Embed compliance with residents' rights into daily practice, governance structures,

and quality monitoring.

#### Action

The following corrective and preventive actions have been implemented and embedded:

##### 1. Smoking Facilities

- Designated smoking areas have been established across the campus, ensuring equitable access for residents in all units.
- Smoking areas are compliant with regulatory requirements and aligned with health, safety, and welfare at work legislation, while respecting residents' rights and choices.
- Clear signage and communication have been implemented to ensure safe and appropriate use by residents, staff, and visitors.

##### 2. Activities Provision and Recreation

- Activity schedules have been expanded across all units, ensuring residents in the main building have the same opportunities for engagement as those in the Clevis Unit.
- Evening and weekend activity programmes have been introduced, with unit staff supported and enabled to facilitate activities outside the activities coordinator's core hours.
- A weekly Wednesday social event, facilitated by volunteers, continues to provide inclusive social engagement, with additional evening initiatives planned.
- Each unit now maintains an Activities Folder documenting:
  - Daily activities,
  - Evening and weekend programmes, and
  - Resident participation and preferences.
- These folders are overseen by Clinical Nurse Managers, ensuring consistency, equity, and quality across units.
- Activity planning is person-centred, informed by residents' interests, capacities, and expressed preferences through residents' meetings and informal feedback.
- Participation is voluntary, and residents' choices not to engage in activities are fully respected.
- In addition to the activities team, residents have access to a wide range of diversional and therapeutic supports, including:
  - Occupational Therapy,
  - Physiotherapy,
  - Chaplaincy, and
  - Volunteer-led engagement.
- Inclusive participation has been evidenced through centre-wide events, such as Halloween celebrations across all units.

##### 3. Visitors' Rooms and Privacy

- Visitor rooms have been reconfigured and enhanced to ensure residents can receive visitors in private, dignified, and comfortable environments.
- Furniture and room layouts have been adjusted to promote comfort, confidentiality, and meaningful family interaction.

##### 4. Residents' Voice, Participation, and Governance

- Residents' meetings have been strengthened through the introduction of clear processes to:
  - Record concerns and suggestions raised,
  - Assign actions and responsible persons, and
  - Track progress and outcomes.
- Outcomes of residents' meetings are now documented and communicated back to residents, ensuring transparency and closing the feedback loop.

- Governance oversight ensures that residents' feedback directly informs service planning, activity provision, and environmental improvements, embedding residents' rights into operational decision-making.

Result / Outcome

- All residents now have equal access to smoking facilities, meaningful activities, and recreation opportunities, irrespective of unit location.
- Activities are available daily, including evenings and weekends, and are tailored to residents' interests, capacities, and choices.
- Visitors' rooms provide private, appropriate environments for family and social interaction, supporting dignity and relationships.
- Residents' concerns are systematically recorded, actioned, and fed back, ensuring genuine participation in the organisation of the centre.
- These measures address the repeat finding, embed residents' rights into daily practice and governance, and position the centre to demonstrate full and sustained compliance with Regulation 9 at the next inspection.

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## Section 2:

### Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 7 (1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition or conditions of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	15/01/2026
Regulation 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a	Substantially Compliant	Yellow	31/01/2026

	suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.			
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.	Substantially Compliant	Yellow	10/11/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/01/2026
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	31/12/2025
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	Not Compliant	Orange	10/01/2026

	the statement of purpose.			
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	10/01/2026
Regulation 26(1)(c)(vi)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control infectious diseases.	Not Compliant	Orange	15/12/2025
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Not Compliant	Orange	15/12/2025
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Not Compliant	Orange	15/12/2025

Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Not Compliant	Orange	15/12/2025
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Not Compliant	Orange	15/12/2025
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Not Compliant	Orange	15/12/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	15/12/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	15/12/2025
Regulation 28(1)(d)	The registered provider shall make	Not Compliant	Orange	12/11/2025

	arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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	Orange	31/01/2025
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	Not Compliant	Orange	17/11/2025

	the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	10/12/2025
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 manage behaviour that is challenging.	Substantially Compliant	Yellow	15/12/2025
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	17/11/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the	Not Compliant	Orange	31/01/2026

	designated centre concerned.			
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