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:	Droimnin Nursing Home
Name of provider:	Droimnin Nursing Home Limited
Address of centre:	Brockley Park, Stradbally, Laois
Type of inspection:	Unannounced
Date of inspection:	08 August 2025
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0047878

About the designated centre

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

Droimnin Nursing Home is a designated centre for older people. The centre has one building that is purpose built. The centre provides accommodation for a maximum of 70 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence basis. The centre is located at the end of a short avenue in from the road and within walking distance to Stradbally, Co Laois. A variety of communal rooms are provided for residents' use including sitting, dining and recreational facilities. Each resident's dependency needs is assessed to ensure their care needs are met.The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, activity, administration, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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
Friday 8 August 2025	08:50hrs to 17:00hrs	Sean Ryan	Lead
Friday 8 August 2025	08:50hrs to 17:00hrs	Susan Cliffe	Support
Friday 8 August 2025	08:50hrs to 17:00hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

Residents living in Droimnin Nursing Home gave mixed feedback about the service they received. They said that they felt safe, and valued the support they received from staff but reported that the care was not always consistent or in line with their preferences. Residents reported some improvement in the provision of group activities supported by newly appointed staff, although these were not provided everyday or on a consistent basis.

Inspectors arrived unannounced to the centre in the morning and were met by a clinical services director and a clinical nurse manager. On arrival, the management team informed inspectors that work was ongoing to address staffing deficits on the day of the inspection. Inspectors immediately undertook a walk around the centre, allowing time for these staffing matters to be addressed, and for any requested documents to be gathered. During the walk around the centre, inspectors met with residents, staff and visitors, and observed both the care environment, and the quality of care, being provided to residents. Following this, inspectors met with the clinical services director, who was deputising for the person in charge, and the clinical nurse manager for the opening meeting.

Inspectors met with a number of residents in their bedrooms and spoke with them, in detail, about their experience of living in the centre. During these conversations, some residents were awaiting assistance with personal care, and requested that the inspectors would meet with them later in the communal areas. Inspectors subsequently spent time in the communal areas, engaging with residents and visitors, and reviewing documentation.

Residents spoke positively about staff, who, in their view, did their utmost to provide consistency and continuity in daily care. However, residents also highlighted challenges when new or unfamiliar staff were assigned to support them. They reported that such staff did not always know their personal preferences, and, at times, residents felt they were not listened to, or had to provide direction on how tasks should be carried out. One resident described having to wait for assistance with personal care for up to an hour, as staff were busy assisting other residents.

One resident was observed sitting in a wheelchair in the seating area in the foyer in a state of undress. This resident informed the inspector that they were cold. Several staff members walked passed the residents without taking action to protect their privacy or attend to their comfort needs.

Inspectors also met with visitors in the communal areas and discussed their experience of the service. Visitors generally complimented staff and added that they "did a good job and did the best they could". They confirmed awareness of the complaints procedure and stated that any issues previously raised had been addressed directly with the previous person in charge. However, they added that the management team did not always respond to issues raised in a timely manner.

While they knew who to approach with a complaint, some visitors were unaware that the person in charge of the centre had recently changed, and expressed concern about the communication of this information.

Inspectors observed the residents' mealtime experiences in the dining rooms. Residents were assisted to the dining room, however, there was a noticeable wait between the time they arrived in the dining room and the time meals were serviced. During this period, residents were not informed of the reason for the delay. On the ground floor of the centre, the atmosphere was calm and relaxed. Staff were present, assisting residents in a kind and patient manager, and nurse managers were actively supervising the mealtime experience. In contrast, the mealtime experience on the first floor was not delivered to the same standard. Residents informed the inspectors that the environment was excessively loud, with inappropriate music playing. They stated that the atmosphere was among the noisiest they had ever experienced, which impacted on their ability to enjoy their meal.

Some residents spoke to inspectors about the quality of the food they received and highlighted that they required specific diets due to their medical conditions. For example, a resident informed inspectors that they had diabetes. When inspectors checked this information in the kitchen, it was found that not all staff had access to a care plan associated with residents nutritional care needs and were therefore unaware of these requirements. A notice board in the kitchen contained information relating to residents nutritional needs, and this board was observed to be used by staff, who used the information as their guide to delivering care. However, a review of this information found that the details were not accurate and did not reflect the actual needs of the residents, as described in their care plan.

Inspectors observed that planned daily activities were displayed on an information board. The schedule included a coffee morning, and live music in the afternoon. While sitting in communal areas, inspectors observed other activities taking place. These included an exercise class on the first floor, a game of bowling in which individual residents participated, and nail care. However, inspectors observed that residents who remained in their bedrooms, either by choice or due to their care needs, spent extended periods of time without any social engagement. In particular, residents with complex care needs were not provided with activities that supported meaningful social interaction.

Residents were observed receiving visitors throughout the inspection in both their bedroom accommodation, and designated visiting areas.

The following sections of this report detail the findings with regard to the capacity and capability of the provider, and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social service to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- review the detail of a representation, submitted by the provider following the issuing of a notice of proposed decision to attach a restrictive condition to the registration to stop admissions to the designated centre.
- review unsolicited information received by the Chief Inspector, pertaining to serious concerns regarding the care and safety of residents, and to assess the actions the provider committed to in a Provider Assurance Report (PAR), issued as a result of these concerns.

The findings of this inspection were that the registered provider had failed to put effective management structures and systems in place to ensure that the service provided was safe and appropriately monitored. An unclear organisational structure, and ineffective management systems of monitoring and oversight, significantly impacted on the quality and safety of the care provided to residents.

Inspectors reviewed the detail of unsolicited information received by the Chief Inspector in relation to poor standards of care provided to a resident, and the associated risk to the care and welfare of residents. This information was substantiated on this inspection.

Droimnin Nursing Home Limited is the registered provider of Droimnin Nursing Home. Following consistently poor regulatory compliance over repeated inspections, in July 2025, the Chief Inspector of Social Services issued a notice of proposed decision to attach a condition to the registration of the designated centre. The purpose of this condition was to stop new admissions to the centre until the Chief Inspector was satisfied that the provider had in place an effective governance and management structure, and had achieved compliance with key regulations that underpinned the quality and safety of care provided to residents.

This is the second time that the Chief Inspector has issued such a notice of decision. In January 2024, in response the concerns about the care and welfare of residents, a restrictive condition preventing admissions was attached to the registration of this designated centre. That condition remained in place until May 2024, when inspectors found that the registered provider had implemented significant improvements to the care of residents, such that, inspectors were satisfied that the nursing home could reopen to admissions.

In response to the July 2025 notice of proposed decision, the registered provider made representation detailing the action that had been taken by the provider to;

- address the non-compliance relating to the governance and management, and the quality and safety of the service through a revised organisational structure.
- implement effective systems of management and oversight to monitor the quality and safety of care provided to residents.

- implement the actions committed to in a compliance plan, urgent compliance plan, and provider assurance report to bring the centre into compliance with the regulations.

In the representation, the provider detailed other action that had been taken to enhance the governance and management oversight of the centre since the last inspection. This included the appointment of a clinical supervisor, an activity supervisor, and the planned appointment of a clinical and quality supervisor. There had also been significant changes in the nurse management structure within the centre, including the appointment of a new person in charge, and there was currently a vacancy in the assistant director of nursing position. The newly appointed person in charge was on planned leave at the time of the inspection, and a group clinical services director was deputising in their absence and was supported by a clinical nurse manager. Inspectors found that the extent of the changes to the organisational structure had resulted in responsibility and accountability for key aspects of the service being unclear, resulting in a failure to monitor critical elements of service provision, particularly the delivery of safe and quality care to the residents, in line with their assessed needs and care plans.

The absence of clear accountability and responsibility extended to the management of the staffing resources. Oversight of staff rosters, allocation and supervision was ineffective, resulting in situations where management personnel were unable to confirm the rosters worked by staff, nor could they confirm if vacant shifts in planned staff rosters had been covered. In the representation, the provider confirmed that an effective rostering system was now in place. However, the system was not in operation on the day of the inspection. This meant that there was no accurate roster available to review. Rosters indicated that certain staff were on duty, when in fact they were not, and rosters for previous days did not demonstrate that vacant shifts had been covered. This repeated lack of accurate and timely roster information created significant uncertainty and impacted on the organisation, management and effective delivery of the service.

In the representation, the provider confirmed that new systems had been implemented to monitor and improve the quality of the service. Since the last inspection, the provider had implemented a program of night-time audits, which effectively identified deficits in the quality of care, including issues in relation to medication management, continence and personal care practices, and reported delays in responding to residents requests for assistance. Although audit records indicated that staff received on-the-spot correction, the effectiveness of these interventions was unclear, as similar incidents that occurred in June had reoccurred in July and August. For example, incidents had occurred in June whereby residents were found to have been left sleeping in their chairs overnight as staff had failed to attend to them. Despite this issue being investigated at the time, appropriate action had not been taken and similar incidents were found to have repeated in the July and August audits of resident care. In addition, there had been no analysis of the audit findings to determine if there were contributing factors such as deficits in staff knowledge, or if staff training and supervision was required.

Furthermore, while the provider outlined revised systems to monitor the quality of residents' clinical care, including wound care, inspectors found that these systems were not fully, or effectively, implemented. For example, although there was evidence of wound assessments being completed in line with the actions commited to by the provider, the system had failed to identify that residents' wound management plans, including frequent repositioning of residents, were not being fully implemented in practice.

There was ineffective oversight and implementation of the systems in place to manage risk and incidents. A review of incidents involving residents in the centre found that the provider had not ensured the incidents, accidents and safeguarding concerns were appropriately managed and documented. Incidents reviewed did not have the results of investigations or action taken documented as required.

Furthermore, incidents recorded on the system had not been subject to an appropriate management review. This included incidents involving a resident who had experienced two falls, after which a falls management plan was prescribed but not implemented. The falls management plan detailed interventions to be put in place such as, sensor alarm mats and large signage to direct the resident to the location of their call bell to request assistance from staff should they wish to mobilise. However, these measures were not put in place and the resident subsequently experienced a third fall. There was no evidence of management review of these incidents.

A review of the management of records found continued issues of non-compliance with the requirements of the regulations. The system in place to record the rostering and attendance of staff in the centre was not effective and resulted in a confused and inaccurate staffing roster. This had been a finding of a previous inspections since November 2024. Records relating to the care and treatment provided to residents, as well as records of complaints, were also not appropriately maintained.

The systems in place to communicate key clinical information between staff were not effective. While staff confirmed that they attended structured handovers, information essential to the delivery of person-centred, safe and quality care was not consistently communicated. This included details relating to the complex supervision needs of some residents, falls management plans, and specific therapeutic nutritional plans. This compromised the overall quality and safety of care delivered to residents.

Inspectors found that staff were not adequately supervised to ensure safe and effective care was provided to residents. While the provider had proposed enhanced care supervision by senior nurse managers to monitor standards of care, these measures were not implemented in practice. As a result, there was insufficient allocation, supervision, and support of staff which directly impacted on the consistency and quality of care provided to residents.

In recognition of identified deficits in wound care, the provider committed to ensuring that nursing staff completed additional training in the management or wounds and pain. However, inspectors found that not all staff had undertaken the

relevant training required for the care and management of residents with wounds. Furthermore, staff were not aware of a requirement to complete additional training in relation to pain management.

Regulation 15: Staffing

There was sufficient staff on duty to meet the needs of the current residents, having regard to current occupancy of the centre, for the size and layout of the centre.

However, while staffing levels were adequate for the number of residents accommodated, the organisation, management and supervision of staffing was not effective. This impacted the quality and safety of care provided to residents. This is addressed under Regulation 23, Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had not been facilitated to complete appropriate training in relation to pressure area care, wound management, and pain management, within the time frame committed to by the registered provider.

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of residents. This was evidenced by the registered provider's failure to;

- Ensure the effective supervision of staff. For example, staff who required guidance were not supported and supervised appropriately.
- Provide an appropriate level of staff supervision, monitoring and support to ensure that the health and social care needs of all residents were consistently met in a timely manner, and to ensure that the recommendations of allied health care professionals were implemented.
- Ensure communication of key clinical information to staff including fall prevention management plans, exercise plans and wound management plans for residents. For example, information communicated by staff to inspectors in relation to the care of residents at risk of impaired skin integrity and at risk of falls was inconsistent, and did not align with the information contained in residents individual care plans.
- Ensure the consistent and effective care of residents with pressure ulcers, complex behaviour and supervision care needs, and nutritional care needs.
- Adequately supervise staff to ensure that residents mobility and transfer care needs were managed in accordance with their individual care plans. For example, inspectors observed a resident who required supervision when

mobilising due an increased risk of fall's mobilising independently without supervision.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

A review of the management of records found that it was not in line regulatory requirements. For example;

- Records of specialist treatment, nutritional care and nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). Records of repositioning charts for residents at high risk of pressure ulcers were not maintained in line with the resident's care plan. Records of nutritional care provided to residents at risk of malnutrition were not maintained in line with the residents care plan.
- Incidents relating to residents' care and potential safeguarding issues were not documented or investigated in line with the requirements of Schedule 3(4)(j). This included the results of any investigation and the actions taken.
- Staff rosters did not reflect the staffing levels on the days of inspection or on the days prior to the inspection and did not include all staff working in the designated centre as required by Schedule 4(9). In addition, the roster indicated that certain staff were scheduled for particular shifts, but it had not been updated to reflect that certain staff had not actually completed the shifts as rostered.
- A record of complaints, including any reviews of the complaints and the action taken by the registered provider in respect of any such complaints was not maintained in line with the requirements of Schedule 4(6). For example, a complaints in relation to the quality of care provided to a residents had not been recorded in line with regulatory requirements.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. A review of staff rosters showed that planned staffing levels were not consistent with the levels commited to by the provider and did not reflect the actual attendance of

staff in the centre. There was significant uncertainty as to whether vacant shifts in the health care staff roster had been filled, both for the days reviewed and for the upcoming roster periods.

The registered provider failed to ensure there was an effective management structure, with clear lines of accountability and responsibility in place. Staff members, residents and visitors were unclear as to who was the person in charge of the centre.

The organisational structure, as described in the centre's statement of purpose was not in place. The specific roles of the nurse management team were not clearly defined. As a result, accountability and responsibility for the oversight and monitoring of key aspects of the service were unclear. This included risk management systems, incident management systems, and the staffing resources. This resulted in the failure to monitor critical elements of service provision, particularly the delivery of safe and quality care to the residents, in line with their assessed needs and care plans.

The poorly defined organisational structure impacted on the management systems in place to ensure the service provided was safe and appropriately monitored. This was evidenced by;

- The registered provider had not ensured that there were effective oversight arrangements in place to ensure the needs of all residents were met, particularly in terms of the arrangements for health care, assessments and care planning. As a result, residents were exposed to risks and did not receive the standard of care necessary to safeguard their health and well-being.
- A failure to implement the centre's risk management systems, to monitor and manage known risks with the potential to impact safety and welfare of residents living in the centre. Known risks, including those arising from ineffective governance and management, had not been assessed, recorded, or managed in accordance with the centre’s risk management policy. Furthermore, the provider failed to appropriately document and investigate potential safeguarding incidents arising from audits of the quality and safety of care. For example, the provider had identified that the standard of personal care provided to some residents was poor. However, these incidents were not recognised as potential safeguarding issues.
- The incident management system was not effective. A significant number of incidents involving residents open on the incident management system had not been reviewed. Among these were incidents of repeated falls, which the nurse management team confirmed had not been assessed or reviewed. Subsequently, further fall incidents occurred, indicating that no evaluation had been made of the effectiveness of actions implemented to prevent recurrence.
- Record management systems were ineffective. There was poor oversight of the management of records pertaining to staff rosters, incidents involving residents and of the nursing care and treatment provided to residents.
- Inadequate oversight of the centre's complaints management system, to ensure complaints were managed in line with the requirements of the

regulations. For example, concerns regarding the care of a resident who required transfer to the acute health care services and the quality of care they received, had been brought to the attention of the management team. The complaint had not been acknowledged, documented, or investigated in line with the centre's own policy.

- The system of communication within the centre was ineffective. For example;
    - Information in relation to residents mobility care needs, falls risk and preventative actions, and nutritional requirements were not known to all staff responsible for the care of the residents.
    - All catering staff responsible for providing residents with diets aligned to their assessed needs and expert recommendations were not informed of residents' nutritional risks or prescribed diets and the information they were accessing on the day of inspection was incorrect.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

Inspectors found that aspects of the quality and safety of care provided to residents was impacted by inadequate governance and management arrangements described under the Capacity and Capability section of this report. This inspection identified poor care delivery, particularly in relation to assessments and care planning, health care provision, and residents' rights. In addition, the inspection found that the nutritional care provided to residents did not ensure that their nutritional needs were appropriately met.

The provider had committed to taking action to improve the quality of the nursing documentation with regard to the residents individual assessment and care plans. While there was evidence that residents needs had been assessed using validated assessment tools, the care plans reviewed were not always informed by these assessments, and did not reflect person-centred guidance on the current care needs of the residents. In addition, not all care plans were reviewed as the residents' condition changed or when a deterioration in their condition was observed. Staff were not provided with timely and clear guidance on the appropriate delivery of care.

In representation, the provider had committed to ensuring that systems were established and implemented to monitor residents' health care needs. This included daily senior nurse management review of residents to support timely referral to medical and health care professionals for further expert assessment when clinically indicated. The provider had also confirmed that systems were in place to ensure there was management oversight of the implementation of recommendations made

by health care professionals. While there were arrangements in place for residents to access the expertise of other health care professionals, referrals for further expert assessment were not always completed in a timely manner. A review of one residents file found that a referral was delayed despite a requirement being indicated within a residents' medical notes. For example, a resident had not been re-referred for further nutritional assessment following continued weight-loss, in line with the recommendation of the dietitian. In addition, inspectors found that the recommendations of health care professionals were not always implemented in practice. This significantly impacted the health and welfare of residents and demonstrated that the systems in place to ensure the provision of appropriate health care to residents was ineffective. This issue was compounded by a lack of robust auditing and monitoring as described in the earlier section of this report.

A review of the nutritional aspects of the service found that the provider did not have robust arrangements in place to identify clinical nutritional risk and monitor the nutritional care needs of residents. Although nutritional screening was carried out for all residents, the assessment of residents' weights, in conjunction with the screening tool necessary to identify those at risk of malnutrition was not always appropriately implemented. Consequently, the care pathway for some residents at risk of malnutrition was not initiated, and no action was taken for a number of residents experiencing weight-loss. Further findings are discussed under Regulation 18, Food and Nutrition.

The protection of residents in the centre was underpinned by policies and procedures that set out the organisation's approach to safeguarding and protection of residents. However, this inspection found that the provider had not effectively implemented these policies and procedures in relation to the identification, investigation, and response to safeguarding concerns. This included a failure to ensure that all staff were appropriately trained and that all potential safeguarding incidents were investigated.

While some group activities were taking place on the day of this inspection, the overall provision of meaningful, person-centred activities remained limited. In particular, activities designed as therapeutic interventions to support residents with complex care needs were not being implemented. In addition, residents were not always kept informed or consulted about the organisation and operation of the centre.

Regulation 18: Food and nutrition

Food and nutrition was not delivered to residents in line with regulatory requirements. This was evidenced by;

- Residents' dietary needs were not consistently met, as prescribed by health care professionals. Several residents were prescribed therapeutic diets tailored to their specific medical conditions such as renal or diabetic diets.

This information was not known to all staff preparing resident meals, or to the staff providing nutritional care to the residents.

- The food provided to residents was not wholesome and nutritious as prescribed by health care professionals. Several residents were prescribed diets that were high calorie and high protein to support the management of their weight. However, the food was not prepared or served in accordance with these requirements.
- Residents were not offered choice at mealtimes, particularly regarding their preferred beverages to accompany meals. Several residents requiring high-protein, high-calorie foods and milk were not provided with these options. Instead, they were served cordial without being offered a choice.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The registered provider had failed to take effective action to comply with the requirements of this regulation. For example;

- Care plans reviewed were not guided by a comprehensive assessment of the residents' care needs. For example, an appropriate care plan had not been developed for a resident who had experienced significant weight-loss and a deterioration in their overall health condition. Consequently, staff did not have accurate information to guide the care to be provided to the resident.
- Care plans were not updated when a resident's condition changed and did not incorporate the recommendations of health care professionals following expert assessment. The care plan for a resident who had sustained repeated falls was not appropriately reviewed, and their fall management plan was not reassessed to determine its effectiveness.
- Where care plans were developed, the registered provider failed to ensure that residents received care in line with their assessed needs and care plans. For example, residents assessed as requiring enhanced supervision, frequent skin integrity checks and repositioning, and specific one-to-one activities to support management of their complex behaviours still did not receive this care

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

The registered provider failed to provide appropriate medical and health care including a high standard of evidence-based nursing care, in accordance with professional guidance. This included a failure to;

- refer a resident to an appropriate health care professional for further expert assessment despite continued weight-loss, in line with the residents care plan or the directive of health care professionals that a referral should be made should weight-loss persist. In addition, there had been no review of two residents weights following significant and continued weight loss.
- ensure arrangements were in place to implement the recommendations and interventions prescribed by health care professionals following expert assessment. Residents prescribed care interventions by physiotherapists, tissue viability nursing experts, and dietitians did not receive care in line with the recommendations of those professionals. For example, residents who were prescribed a daily mobility exercise plan and specific fall prevention actions did not have these interventions carried out. Furthermore, a resident who had been prescribed a wound management plan that included frequent repositioning did not have this plan implemented. This significantly compromised the quality of care provided to the residents.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse. This was evidenced by a failure to;

- appropriately investigate incidents of allegation of abuse and safeguarding concerns. For example, the provider had been made aware of several care incidents indicative of potential safeguarding issues. However, these incidents were neither documented or investigated in accordance with the centre's safeguarding policies and associated procedures.
- ensure that all staff were provided with up-to-date training in recognising and responding to allegations of abuse.

These are repeated findings from previous inspections.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider failed to ensure that residents' rights were upheld within the centre.

- Residents who required the provision of person-centred activities as a therapeutic intervention to support the management of their symptoms of dementia were not provided with such activities. For example, the care plans for some residents outlined a requirement for specific one-to-one activities intended to provide stimulating engagement and assist residents in managing behaviours associated with their dementia. However, a review of the records, discussions with staff, and the inspector's observations showed that these activities were not being implemented.
- Residents who chose to remain in their bedrooms, or who spent a significant amount of time there and did not participate in group activities, did not have their social care needs met in line with their assessed needs and care plans. This resulted in those residents experiencing a lack of meaningful engagement and stimulation, contrary to the person-centred approach set out in their care plans.
- Residents expressed concern about the lack of information provided in relation to the organisation of the service and explained that while they had overheard partial information from staff in relation to changes to the management structure and they were unsure as to who was in charge of the centre.

This is a repeated non-compliance.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0047878

Date of inspection: 08/08/2025

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Staff training for pressure area care, wound management and pain management by a third-party provider has been booked for October 17th and 21st.

• The Clinical Operations Manager, PIC, ADON and CNM are supervising nursing and HCA staff and care provided to residents on the floor on a daily basis to ensure timely care is received by residents in accordance with recommendations by medical and allied health professionals.

• In addition, senior HCAs and department leads are present daily and are supervising non-nursing staff to ensure that each department functions appropriately and consistently delivers a safe and effective service.

• Effective from 06/10/2025, the Independent Nurse Consultant is now overseeing the timely delivery of clinical care through daily reviews of residents' health care records and medication administration records on a remote basis to ensure that there is documented evidence that all care is delivered and that actions are completed in a timely manner. The reporting function and dashboard of the electronic record system is utilized to specifically identify residents at high risk, where a complaint or incident has been raised or residents whom have been recently reviewed by their GP or an allied health professional, however all residents will be reviewed. Daily emails to the senior management team are then issued to direct and guide care based on these reviews of individual residents' records. Responses from the team in terms of the progress achieved each day are then returned to the Independent Nurse Consultant for further review and any outstanding items or further actions required are then reissued. This means that there is now daily oversight in real time of issues presenting and care delivered. This remote review is then supplemented by twice weekly visits by the Independent Nurse Consultant to the nursing home to meet with individual residents in person, identify any

other needs and to ascertain the residents' level of satisfaction with the care delivered.

• A new daily handover sheet commenced from 18/08/2025 to enhance communication between the team. This identifies individual residents' needs and tasks to be completed. Effective from 06/10/2025 it is now reviewed and updated daily by the CNM and checked again by the ADON before it is issued to staff.

• Each nurse is undergoing a full review of current practice, with strengths and areas for improvement identified by the Clinical Operations Manager and ADON. This is supported by the Independent Nurse Consultant who is also identifying potential staff performance issues based on documentary evidence reviewed. Based on this feedback, the HR Manager will then implement a tailored training and support plan for each nurse to address any deficits found (e.g. retraining, enhanced supervision, etc). Alternatively disciplinary action will be taken where required.

• An annual appraisal system, incorporating both self-assessment and management feedback, will be conducted. This will allow progress to be measured against set objectives and provide a formal record of knowledge, skills and competencies.

• The HR Team in conjunction with the Independent Nurse Consultant are reviewing our induction programme for all staff to ensure that the fundamentals of safe care, as well as the expectations of regulatory compliance, are embedded from the outset.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 21: Records	Not Compliant

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

• A new Standard Operating Procedure will be developed by the Independent Nurse Consultant to set out expected daily recording of care provided on the electronic resident record. This will indicate specific detail and options to be chosen for each element of care provided so that there is consistent documentation of practice and no ambiguity among staff.

• Daily reviews of repositioning records and food and fluid intake are now being conducted both in real time by the Senior HCA, nurse on duty on each floor and by senior management together with retrospective reviews by the ADON on a daily basis. This is overseen by the PIC, the Out-of-Hours Supervisor and the Independent Nurse Consultant to identify any staff performance issues or significant gaps in records. Monthly audits will be conducted by the Clinical Operations Manager.

• All incidents occurring and potential safeguarding issues will now be reported daily by

staff, an incident report documented, and witness statements taken on the same day. Any additional issues identified through daily reviews of electronic resident records by the Independent Nurse Consultant that have not been recognised or responded to by the Senior Management Team will be highlighted immediately and appropriate action taken. External training in respect of completing witness statements and incident forms has been booked for staff.

• The Clinical Operations Manager has now taken ownership of the roster system to ensure accuracy and completeness and timely updates.

• Effective from 06/10/2025, complaints are now discussed daily at clinical handover to ensure all complaints are identified and logged by staff. This will be overseen by the senior management team within the centre. Oversight of the complaints register is now undertaken daily by the Independent Nurse Consultant to ensure all complaints are appropriately responded to and recorded in line with regulatory requirements and twice weekly visits will provide a further opportunity to check in with individual residents to highlight any additional complaints that may have been raised but not recorded. Complaints are also discussed at the weekly management meeting, and any learning is shared with staff on daily huddles/staff meetings.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 23: Governance and management	Not Compliant

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

• The Provider has already notified the Chief Inspector that they are imminently working towards securing a new governance and management structure that will provide the necessary assurances that the service provided is safe, effective and consistently monitored. This new structure is envisaged to be in place within the coming weeks.

• In the interim, the Independent Nurse Consultant is being appointed as a Non-Executive Director of the Board of Brookhaven Healthcare, and as already highlighted is conducting daily remote reviews of individual resident records (healthcare and medication administration records) and directing, guiding and overseeing the clinical care provided to residents. This is supplemented with twice weekly visits to the nursing home to speak with residents and staff and ensure all issues are appropriately recognised, responded to, investigated and recorded.

• An improved management structure with clear roles and responsibilities for each management position is now in place and known to staff. The structure is displayed in staff areas and communicated to all staff, residents, and visitors. The Person in Charge (PIC) has full authority for the day-to-day running of the centre. The ADON and Clinical Operations Manager support the PIC by overseeing clinical and operational areas. This will be overseen by the Registered Provider and the Independent Nurse Consultant, through daily updates, weekly governance updates and monthly governance reports.

• The Clinical Operations Manager has now taken ownership of the roster system and to ensure accuracy and completeness and timely updates. Any unfilled shifts or short-notice unplanned absences are now escalated immediately to the Clinical Operations Manager for cover.

• A workforce plan is under review by the HR Manager to ensure all departments are adequately and consistently staffed (without the need for redeployment of staff) and that short-notice unplanned absences are adequately identified, responded to and proactively managed to limit the impact on service provision. A new PIC and ADON are due to commence on October 20th. Further a new fixed term contract has been issued for a new Clinical Quality Supervisor commencing on October 13th to improve the daily supervision of residents on a daily basis.

• Risk management, incident management, record management and complaints management systems are now being reviewed daily with weekly reporting to the Provider and Board of Management. Falls and recurrent falls incidents are now reviewed by the Physiotherapist/ physiotherapy assistant. A new clinical handover sheet has commenced from 18/09/2025 to improve communication between the team and this is being updated by the CNM and overseen by the ADON on a daily basis effective from 06/10/2025.

• A new comment box has been placed in the staff canteen to enable staff to raise any concerns about the quality and safety of care. These concerns can also be raised anonymously if the staff member wishes to do so. This box will be emptied by the Independent Nurse Consultant each week, analysed and ensuring that all comments about individual residents or staff are reviewed, logged on the relevant system, fully investigated (where sufficient detail has been provided) and issues will be discussed at clinical governance and staff meetings to ensure all staff are aware of concerns raised and the plan to address these.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• An external nutrition consultant has completed a full review of all residents' dietary needs. This information has been shared with the catering team and uploaded to the clinical management system, so it is accessible to all staff. Each resident's current dietary requirements, including any therapeutic or modified diets such as diabetic, renal, or high-protein/high-calorie diets, are now clearly identified in the kitchen and dining areas using updated dietary information sheets. These are checked weekly and updated immediately if there are any changes following dietitian or SALT (Speech and Language Therapy) reviews. The Clinical Operations Manager is responsible for ensuring these updates are completed promptly. Kitchen and care staff receive daily handovers on residents' dietary needs before each meal service.

• Food and fluid intake records have improved oversight and are now consistently recorded so that there is documented evidence of food types and quantities consumed. This occurs in real time by the senior HCA, nurse on duty and overseen by the senior management team and by daily reviews of resident records by the Independent Nurse Consultant.

• All residents have now been placed on weekly weights to ensure there is timely monitoring and reassessment of the risk of malnutrition and to ascertain whether their dietary needs are being consistently met. A six-month weight change report is now being run weekly to review the effectiveness of the changes being implemented and closely monitor the changing status of individual residents' needs, ensuring that their MUST assessments and care plans are updated in a timely manner.

• A Head Chef has been appointed from October 08th. They are supported by 2 kitchen assistants daily and from 06/10/2025 a short term contract with agency staff is being executed to ensure there is consistency of staffing in this department to avoid the need for redeployment of staff from other duties. This is overseen by the Facilities Management Project Manager to ensure all systems and processes are consistently followed.

• All meals are now planned and prepared by the Head Chef in line with residents' individual nutritional requirements and dietitian recommendations. Menus have been reviewed to ensure high-protein and high-calorie options are provided where prescribed. The Clinical Operations Manager and ADON reviews meal quality and presentation daily on both floors to ensure meals are wholesome, nutritious, and appealing and are appropriate for the needs of residents with specialised dietary requirements.

• Residents are now offered clear choices of meals and drinks at each mealtime, including preferred beverages such as milk. Staff are reminded daily to offer and record residents' choices. Managers complete meal service observations to ensure residents receive choice, support, and time to enjoy their meals.

• From 20/09/2025 following nighttime observations by the Independent Nurse

Consultant, a selection of high protein sandwiches is now available each evening and night for residents.

• Monthly audits will be conducted on the mealtime experience and appropriateness of specialised diets served.

Food quality, quantity and presentation will feature as a standing item agenda on Resident Committee meetings and resident feedback will be proactively sought through twice weekly visits from the Independent Nurse Consultant and the Group Advocate.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• All residents have now undergone a full reassessment of their needs to ensure care plans accurately reflect their current health, mobility, nutritional, and behavioural support needs. Residents who have experienced changes in condition, such as weight loss or repeated falls, have been prioritised for immediate review and correction of any gaps. This has been supported by a full in-person GP review of each residents' individual needs.

• A new Activities of Daily Living (ADL) care plan template has been introduced, consolidating all previous plans into one personalised, easy-to-follow document for each resident. This ensures all areas of care — clinical, social, and emotional — are captured in one place, avoids repetition and enables a faster navigation and updating of records. This process is nearing completion for all residents.

• The senior nurse management team are also conducting regular monitoring of documentation to identify and correct any issues such as copying and pasting, duplication, or inaccuracies. Immediate feedback and support are provided to staff where required.

• The Independent Nurse Consultant is conducting daily remote reviews of individual resident records (healthcare and medication administration records) and directing, guiding and overseeing the clinical care provided to residents. This is supplemented with twice weekly visits to the nursing home to check in-person the quality and standard of care delivered and to consult with individual residents on their lived experience.

• All nurses have scheduled refresher training on assessment and care planning by an external contractor, focusing on person-centred documentation and timely updates when residents' needs change. Training booked for October. Ongoing coaching is provided to any staff requiring additional support by the senior nurse management team (including the Clinical Operations Manager and Out-of-Hours Supervisor).

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• Residents identified during the inspection have now been referred to and reviewed by a dietititan and their recommendations updated in the residents' care plans. Residents on daily mobility exercise plans are supported through the physiotherapist and physiotherapy assistant when onsite and by HCAs outside of these times. Repositioning is now implemented for all residents at risk of pressure damage or whom have an open wound and these interventions are now fully recorded and overseen in real time by senior HCAs, nurse on duty and senior management on the floor.

• Each resident is now weighed weekly and reviewed for changes in weight, skin condition, and general health. Any continued or unexplained weight loss is immediately reported to the CNM and referred to the appropriate health professional (GP or dietitian) for assessment. The CNM will ensure referrals are made promptly and outcomes are recorded in the resident's care plan and EPIC record.

• Reports on weight change within the last six-months are now reviewed weekly to closely monitor changes in the residents' weight status and ensuring that any residents with a significant weight loss are recognised, reassessed and referred for specialist input and that their assessments and care plans are updated and communicated to all staff. This is overseen by the Independent Nurse Consultant.

• GP-led reviews of high-risk residents were completed on September 16th, 19th, and 23rd, covering 32 residents. All remaining resident reviews were completed by September 30th, 2025.

• Each resident's new ADL care plan now includes all current recommendations from physiotherapists, dietitians, and tissue viability nurses. Nursing and care staff are briefed daily on these interventions during handover and must record completion of each intervention (such as repositioning, mobility exercises, or wound care) in EPIC.

Outstanding tasks are highlighted in the daily handover sheet to ensure that there is continuous monitoring of interventions required.

• The Clinical Operations Manager and CNM complete daily floor supervision to ensure that all residents receive care in line with current clinical instructions. The ADON reviews one wound management plan and one mobility plan each week to check that interventions match what is prescribed. Any gaps identified are corrected immediately, and additional staff guidance is provided.

• All communication from allied health professionals is now logged and reviewed at the daily morning huddle to ensure recommendations are shared promptly with all staff. Follow-up actions are tracked by the CNM and reviewed in the weekly governance meeting.

• Effective from 06/10/2025, the Independent Nurse Consultant has commenced daily remote reviews of residents' health records and medication administration record to ensure the timely implementation of medical and allied health recommendations. This is supported through the reporting functionality of the electronic health record to track medical and allied health professional visits to the home. Any deficits found are emailed directly to the senior nurse management team, who in turn provide a progress report by way of response at the end of their shift. This is then overseen in person and verified with individual residents on the twice weekly visits to the home. Copies of the emails are available on request if required to provide further assurances.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• All incidents or concerns that could indicate potential abuse are now reviewed daily by the senior nurse management team onsite and overseen by the Independent Nurse Consultant. Any safeguarding concern is logged immediately on the incident management system, investigated in line with the safeguarding policy, and reported to the relevant authorities as required.

• Historical incidents have also been reviewed to ensure all necessary actions and investigations were completed and fully documented and that there are safeguarding care plans in place for residents as required.

• All allegations of abuse which outline potential staff performance issues are now

escalated to the HR manager for appropriate investigation and implementation of disciplinary actions as required.

• All staff have received mandatory and updated training in Recognising and Responding to abuse. No staff are currently overdue this training. Safeguarding induction for new staff has been strengthened to ensure awareness of the signs of abuse and the reporting process from day one.

• In addition, all staff are now completing FREDA principles training (Fairness, Respect, Equality, Dignity, Autonomy) to reinforce respectful, person-centred care and support the prevention of abuse through everyday practice. This training will be completed by October 17th, 2025.

• A weekly safeguarding review has been introduced as part of the clinical governance meetings. All new incidents are reviewed, follow-up actions are tracked, and learning is shared with the team. Outcomes and themes are reported to the RPR and the Board Clinical Governance Committee to ensure accountability at the highest level.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• All residents living with dementia who require therapeutic or one-to-one activities have now been identified. Their care plans have been reviewed and updated to reflect specific activities that help manage symptoms and support well-being. "Key to Me" assessments have been completed for all residents, in consultation with families where required, and these are now incorporated into each resident's care plan. These assessments identify personal preferences, life history, and meaningful activities.

• External activity partnerships have also been established to develop a calendar of regular, varied community engagement activities, ensuring that residents have frequent opportunities for connection, stimulation, and enjoyment.

• Residents who prefer to spend time in their rooms now have individual engagement plans. Each resident is visited at least once per shift by care or activity staff for one-to-one interaction such as conversation, music, reading, or sensory activity. All one-to-one sessions are recorded daily and reviewed weekly to ensure consistency.

• Monthly resident surveys have commenced to gather feedback on activities,

communication, and overall satisfaction with the service. Findings from these surveys are reviewed by the management team and used to inform service improvements. A residents' meeting was held on September 19th, 2025, where survey results were discussed, and actions agreed with residents.

• Regular residents' meetings are now held, led by the Person in Charge and supported by the ADON and CNMs, to ensure residents are kept informed about management, staffing, and upcoming events. Feedback and outcomes from these meetings are shared with all residents.

The provision of activities and documentation of resident participation, together with resident feedback on activities will be overseen by the Independent Nurse Consultant.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	21/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	06/10/2025
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	26/09/2025
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Not Compliant	Orange	26/09/2025
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with	Not Compliant	Orange	03/10/2025

	adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
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.	Not Compliant	Orange	06/10/2025
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	Orange	06/10/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	29/09/2025

	details responsibilities for all areas of care provision.			
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	06/10/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	29/09/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/09/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not	Substantially Compliant	Yellow	17/10/2025

	exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Orange	30/09/2025
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	30/09/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	26/09/2025
Regulation 8(2)	The measures referred to in	Substantially Compliant	Yellow	26/09/2025

	paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	26/09/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	06/10/2025
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 designated centre concerned.	Substantially Compliant	Yellow	26/09/2025