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:	25 June 2025
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0047396

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:	61

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 25 June 2025	09:00hrs to 17:00hrs	Sean Ryan	Lead
Wednesday 9 July 2025	11:15hrs to 18:10hrs	Sean Ryan	Lead
Wednesday 25 June 2025	09:00hrs to 17:00hrs	Sharon Boyle	Support
Wednesday 9 July 2025	11:15hrs to 18:10hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

Overall, residents provided mixed feedback about their experience of living in the centre. While many acknowledged improvements in the provision and variety of activities since the last inspection, some felt that these improvements had not been sustained and that this aspect of the service remained a 'work in progress'. A number of residents spoke in detail about the care they received and their opportunities for social engagement. While they consistently described staff as kind and that they made them feel safe, they felt that staff were often too busy, and on some days, there was a lack of consistency in the care provided, noting that their individual needs were not always understood, or met by staff.

Inspectors were met by the person in charge on arrival at the centre. Following a brief introductory meeting, inspectors walked through the centre to observe the care environment and the quality of care provided to residents. There was a busy atmosphere in the centre on the morning of day one of the inspection.

Residents reported to inspectors that their breakfast experience on the morning of day one of the inspection did not reflect the usual standard, as staff who were unfamiliar with their individual needs were delivering the service. One resident explained that they typically got out of bed and sat on a chair to eat their breakfast. However, on this occasion their breakfast was placed on a table in front of them while they were still in bed. The resident added that they were not comfortable eating in this position, but staff had left the room before they could communicate their preference. Inspectors observed that this aspect of the mealtime experience appeared to be task-orientated rather than person-centred. This was evidenced by further similar observations throughout breakfast time, where resident's individual needs, preferences and routines were not consistently acknowledged or supported.

Staff were observed serving breakfast to residents in their bedrooms while simultaneously responding to call bells. In some instances, residents had their breakfast before receiving personal care in line with their expressed wishes and preferences, and before their bedroom environment was fully prepared to support a comfortable and enjoyable mealtime experience. Staff informed the inspectors that the priority in the morning was to serve residents their breakfast and then return to provide personal care.

Corridors were set up with the necessary equipment for the delivery of care, including linen trolleys and waste bins. However, the linen trolleys were malodorous. Staff confirmed that these trolleys were used by night staff and would not be emptied until later in the morning.

As the morning of day one of the inspection progressed, residents gradually made their way to the communal areas on the ground and first floor. During this time, staff were not consistently available to supervise or support the residents or provide meaningful activities. Some residents appeared to have unmet personal care needs,

such as wearing unclean clothing or otherwise appearing as though their needs had not been fully attended to.

On day two of the inspection, by mid-morning, a number of residents were sitting quietly in the communal day room with little engagement. One resident, who was reading a newspaper told inspectors that no activities had taken place so far that day. They explained that one of the activities staff members was on leave, leaving just one staff member to provide activities to all residents. The resident explained that when this happened, they were unsure whether any activities would go ahead as planned. Another resident said that a staff member had earlier asked if they would like to attend a group activity, and they had agreed, but a significant period of time had passed and no one had returned to bring them to activities.

Inspectors observed that residents were left unsupervised for extended periods in communal areas. While staff occasionally passed through, this was largely to respond to call bells or retrieve items from the clinical room. Catering and housekeeping staff were observed to interact with residents in a kind and polite manner. However, care staff appeared to be too busy to stop and talk as they were occupied responding to other residents' requests for assistance. Some residents, identified as being at high risk of a falling were observed mobilising independently without supervision. Although staff acknowledged that these residents required close monitoring, they stated that they did not have the capacity to provide the necessary level of supervision. However, in the afternoon, staff were observed to be more available and present in the communal areas. They assisted residents with snacks and refreshments, and there were polite and engaging conversations observed between staff and residents.

Inspectors joined residents in the dining rooms during the lunch time meal service. On the ground floor, where the meal was supervised by nurse management, the dining experience was observed to be calm and pleasant for residents. In contrast, on the first floor there was no management supervision. The environment was chaotic, loud and task-orientated. Staff were observed engaging with one another rather than with residents. Some residents did not appear to enjoy the atmosphere and appeared unsettled which impacted on the dining experience for other residents. Two residents told inspectors that they ate their lunch as quickly as possible so they could "leave the dining room to find peace and quiet". Several residents described the experience as loud and uncomfortable.

Inspectors observed that two staff were allocated to distribute lunch trays to residents who choose to eat in their bedrooms. Staff told the inspectors that they were also allocated to assist those residents who required assistance with their meals and to answer calls bells at this time. There were periods, particularly during evening meals, when staff presence in the dining room was inconsistent. Residents informed inspectors that they had been waiting some time for staff to return and provide assistance. Inspectors observed that the call bell was located on the opposite side of the dining room and was out of reach of the residents.

In the afternoon, residents on the ground floor were observed to enjoy the fine weather outside. Residents had access to a courtyard which was well maintained

and had flower boxes with plants which provided a sensory experience for residents. There was plenty of seating for residents to sit and enjoy the outdoors. Inspectors observed that the doors leading to these courtyards were open at all times which made the courtyards easily accessible for residents should they choose to go outside unaccompanied. This area also contained a smoking area for residents.

Inspectors spoke with several visitors who shared their experience of the service and the care provided to their relatives. Overall, they complimented the staff and described them as kind and caring. Some visitors expressed concern that staff appeared to be "under pressure", based on their observations while sitting in communal areas. Visitors demonstrated familiarity with the procedure for making a complaint or raising a concern and felt comfortable sharing information with staff when needed.

Residents spoke positively about the staff allocated to provide them with activities. They knew these staff members by name and felt that as individuals they enhanced the activities experience. However, residents shared examples of days when no activities had taken place. While activities were available on the ground floor, residents on the first floor reported not being given opportunities to attend them. Those on the first floor were observed to be provided with puzzles and colouring books but felt these did not fully meet their individual needs. They expressed a desire for more lively and engaging activities tailored to their preferences.

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

Capacity and capability

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

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address significant issues of non-compliance identified on the last inspection of the centre in April 2025
- review unsolicited information received by the Chief Inspector pertaining to concerns about the quality of care provided to residents, and residents' rights. This information was substantiated on this inspection.

Significant risk and regulatory non-compliance were found on the previous inspection of the centre in April 2025. The provider had failed to ensure that there was an effective organisational structure in place, that there were effective systems of management to monitor the quality and safety of care to residents, and had failed to sustain compliance with key regulations that underpin the care and welfare of residents. Following the inspection in April 2025, the provider was requested to attend a warning meeting with the Chief Inspector where they were advised that

failure to bring the centre into regulatory compliance could result in further escalatory action. The provider was required to submit a compliance plan outlining the actions they would take to address the identified concerns and ensure the safety of residents. This inspection was carried out to assess the implementation of that plan. However, this inspection found that the provider had not taken the necessary action to bring the centre into compliance, and the quality and safety of residents' lives continued to be impacted.

The findings of this inspection were that the governance and management of Droimnin Nursing Home failed to meet the requirements of the regulations. A weak organisational structure and ineffective management systems of monitoring and oversight continued to impact on the quality and safety of the care provided to residents. This was compounded by ineffective oversight, management, and supervision of the staffing resources to ensure residents received care in accordance with their assessed needs and care plans, particularly in the provision of personal care, nutritional care and meaningful activities. As a consequence of these concerns, an urgent compliance plan was issued to the provider following day one of this inspection.

Due to the level of non-compliance on day one of the inspection with the regulations that underpin the care and welfare of residents, a second inspection day was scheduled to review the actions taken by the registered provider committed to in an urgent compliance plan submitted to the Chief Inspector. The provider had committed to implementing a system of oversight by ensuring that key management personnel were responsible for the allocation and supervision of staff, as well as the delivery of care to residents. Additionally, the provider committed to establishing a management roster to ensure continuity in the supervision and oversight of the service. However, on day two if this inspection, inspectors found that the provider had failed to take the required action to ensure the safety and well-being of residents and ensure the effective oversight and supervision of the delivery of care to residents. Consequently, inspectors found a deterioration in the quality and safety of the care provided to residents.

Droimnin Nursing Home Limited is the registered provider of Droimnin Nursing Home. It is a company consisting of three directors, one of whom represents the registered provider in communication with the Chief Inspector. The management structure supporting the designated centre had changed since the previous inspection in April 2025. At that time, governance support and oversight was provided by a regional manager and persons participating in the management of the centre. On this inspection, it was found that the regional manager position was now vacant and the provider had restructured the senior management arrangements. As a result, a person participating in the management of the centre now held direct responsibility for the governance support and oversight of the centre.

Inspectors found that the overall governance and management had not had a significant impact on the quality and safety of the service or regulatory compliance since the last inspection. In particular, some aspects of the service such as the oversight of care provided to residents had disimproved. The management structure within the centre was not clearly defined. Lines of authority and accountability were

not clearly identified. While the person in charge retained overall accountability and responsibility for the provision of the service, inspectors found that key responsibilities were shared across the wider management team. These oversight arrangements did not ensure that delegated areas of responsibility were being effectively monitored as systems to safeguard and protect residents, manage risk, maintain appropriate records, and monitor and supervise the direct provision of care, were not implemented in practice.

The management systems failed to ensure that the service provided was safe, consistent and effectively monitored. While there was evidence that incidents involving residents were being reviewed, the system in place to manage risk was not effective. The centre's risk management policy detailed the interventions that should be in place for the oversight, assessment, and monitoring of risk in the centre. This included maintaining a risk register to record all potential risks to residents' safety and welfare. However, a review of the centre's risk management systems found that they did not reflect the centre's own risk management policy. Known risks, particularly in relation to the governance and management, and staffing, were not appropriately assessed. For example, there was no assessment of risk, or evaluation of residents dependency and care needs prior to reducing staffing levels. Similarly, the decision not to fill vacant shifts arising from planned leave were not underpinned by an assessment of risk or residents' care requirements. This had a negative impact on the quality of care provided to residents. In addition, while potential fire risks were identified, assessed, and controls were developed to mitigate the risk to residents, the provider had not reviewed the effectiveness of existing risk mitigating controls. While works had been carried out to some fire doors and emergency lighting, the assessment of risk in relation to the fire doors and service penetrations and the controls in place to manage the risks had not been reviewed or updated to reflect works completed, and works outstanding.

The organisation, supervision, and management of the staffing resources was not effective and this impacted on the quality of care provided to residents. Although the provider committed to actions within an urgent compliance plan to establish an effective system of supervision, there remained unclear delegation of responsibility and accountability for the daily allocation of staff and for ensuring appropriate staffing levels were maintained. Inspectors reviewed the planned and worked rosters to establish the staffing levels and skill mix in the centre. There were multiple systems in operation to record staff attendance; an electronic planned bi-weekly roster, a paper based roster, a staff allocation form completed daily, and a phone application accessible to staff. The documents reviewed did not accurately reflect the staff on duty on the days of inspection. On day one of the inspection, one system had not been updated to reflect staff unplanned leave or the attendance of agency support staff in the centre. On day two of the inspection, the electronic roster management system had highlighted unfilled health care staff shifts. Although the system had flagged these gaps, no remedial action had been taken by the management team to address the staffing shortfall. This impacted on the quality and safety of the service provided to residents. A lack of a clear procedure to monitor and escalate staffing risks to the provider or a pathway of action to manage unplanned staff leave compounded this risk.

Despite the provider committing to an urgent review of the supervision of staff in the centre, inspectors found that the system in place to supervise and support staff was not effective. Staff were not appropriately supervised in key areas of the service, including the delivery of care in accordance with residents care plans, and providing residents with meaningful activities. This issue was further compounded by some staff being allocated to residents' care without adequate supervision or knowledge of their assessed needs, including personal care, nutritional needs, and mobility support which impacted on the consistency and quality of care provided. This contributed to sub-standard and inconsistent care being provided to residents.

The arrangements in place to ensure the effective clinical supervision of residents with complex care needs was ineffective and did not ensure there was adequate oversight to support safe and appropriate clinical practice. Inspectors reviewed the systems in place to ensure that there was appropriate oversight and supervision of the delivery of direct care to residents. This review found that care records were not maintained in line with the requirements of the regulations. For example, records of nursing care provided to residents at high risk of falls, at risk of malnutrition and at high risk of developing pressure damage to their skin were not consistently maintained in line with the resident's care plan.

Through a compliance plan, the provider had committed to implementing a system to ensure that records were maintained in line with the requirements of the regulations. While the provider had taken action to ensure records of complaints were appropriately maintained, and that staff personnel files were maintained in line with the requirements of Schedule 2 of the regulations, inspectors found that the systems in place to maintain records required by Schedule 3 and 4 of the regulations were ineffective. This included records with regard to the nursing care provided to residents and records of staff duty rosters.

Regulation 15: Staffing

The provider had failed to ensure that there were sufficient staffing levels in the centre to meet the assessed needs of the residents, or for the size and layout of the centre. A review of the rosters found that there was inadequate staff available to meet the health and social care needs of the residents, and to ensure residents received safe and effective care.

- On both days of the inspection, only one staff member was available to deliver the social programme, despite two being required. This was as a result of staff being reassigned to cover a vacant shift in the kitchen. A review of the worked and planned staffing rosters also found that activities staff who were on planned leave were not replaced for up to eight shifts. This impacted on the delivery of social care to residents.
- Residents spoken with voiced their concern with regard to staffing levels. Residents reported, and were observed, spending long periods of time with no social engagement of meaningful activities taking place.

- A review of the staffing rosters showed that the service had been operating with insufficient staffing levels at times, and there was significant uncertainty around the required staffing numbers needed to meet residents' care needs. The rosters reflected inconsistencies in staffing allocations, with fluctuations in the number of staff on duty, and no clear rationale for these variations. For example, the rosters reviewed showed two days where the required number of health care staff were not rostered on duty. This was found to impact on the quality and safety of care provided to residents.
- Residents spoken with reported having to wait a long time for care to be delivered. Inspectors observed that health care staff, allocated to support residents with their nutritional care needs in their bedrooms, were also required to respond to call bells at the same time. This led to delays in some residents receiving their meals and interruptions during mealtimes, as staff were required to attend to other residents requests for assistance.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not appropriate to protect and promote the care and welfare of all residents. This was evidenced by;

- poor supervision of staff to ensure residents received care and support in line with their assessed mobility and nutritional care needs.
- poor oversight of the residents' clinical documentation to ensure the assessment and care planning were accurate and up-to-date to reflect the current care needs of the residents.
- poor fire safety awareness as evidenced by fire doors wedged open.
- A lack of oversight of residents' clinical documentation and communication of key clinical information to ensure diagnostic tests and monitoring of residents were carried out in line with the directions of health care professionals.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

The management of records was not in line with 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). For example, records of repositioning charts for residents of high risk of impaired skin integrity 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. Records of residents locations, maintained for residents assessed as requiring high levels of supervision, were not accurately maintained.
- Records of on-going medical assessment, treatment and care were not consistently maintained, as required by Schedule 3(4)(e) of the regulations. For example, records of residents' diagnostic test results were not maintained in the centre, or available to staff for review.
- Staff rosters did not reflect the staffing levels on the days of inspection. Staff that were on unplanned leave from the centre were not identified as such on the planned or worked rosters provided to inspectors on the morning of the inspection.

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. The provider had failed to ensure that staffing resources were available and appropriately managed in response to planned and unplanned staff leave. This was compounded by significant uncertainty of management personnel within the centre regarding the appropriate and necessary number of staff required to effectively operate the designated centre and to ensure that residents care needs could be met in a timely manner. This failure of staff oversight impacted the quality and safety of the service provided to residents.

The registered provider had failed to ensure that there was a clearly defined management structure in place, with clear lines of accountability and responsibility, in line with the centre's statement of purpose. The roles and responsibilities of the management team were not clearly defined, resulting in responsibilities being delegated to staff without appropriate levels of support and supervision. This resulted in the care provided to residents being inconsistent, uncoordinated and sub-standard. The provider's response to an urgent compliance plan request to address this risk did not provide assurance that the provider had taken appropriate action to address the issues identified.

The provider failed to ensure that the centre had adequate governance arrangements and effective management systems in place to ensure a safe, monitored and consistent service was provided. This was evidenced by;

- compliance plans submitted following the previous inspection and an urgent compliance plan issued following day one of this inspection contained actions that were either not implemented, found to be ineffective, or not sustained. This resulted in repeated non-compliance in multiple regulations.
- a failure to implement the centre's risk management systems to identify and respond to potential risks to residents. For example, despite concerns being raised about the quality of care provided to residents, there had been no assessment of work-force related risks. This included incidents where staff were working without adequate supervision. Furthermore, the provider had failed to implement policies and procedures designed to safeguard and protect residents.
- inadequate systems of communication to ensure all staff had information pertinent to providing residents with person-centred care. As a result, essential interventions and supports required to effectively meet those needs were not consistently communicated to staff or implemented, particularly in relation to residents at risk of impaired skin integrity, falls, and malnutrition.
- ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and health care services, and implementing the recommendations of health care professionals.
- poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to nursing documentation, care and treatment provided to residents, and records of staff rosters were poorly maintained.
- an absence of systems for regular staff supervision and performance reviews. There were no processes in place to evaluate the effectiveness of staff training and development.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

The overall quality and safety of care continued to be impacted by ineffective governance and management. Inspectors found that ineffective management and supervision of the staffing resources impacted on the quality and safety of care being delivered. As a result, care and support was not always provided in line with residents' care plans. The assessment of residents' needs was inadequate and did not ensure the delivery of safe, high-quality, person-centred care to residents. Non-compliance in relation to individual assessments and care plans, health care,

residents' rights and food and nutrition impacted on residents' safety and well-being. In addition, the physical environment did not fully protect residents from the risk of fire.

A sample of residents' individual assessment and care plans were reviewed. There was evidence that residents needs had been assessed using validated assessment tools, and all residents had a care plan. However, the care plans reviewed were not always informed by clinical assessments, and did not reflect person-centred guidance on the current care needs of the residents. For example, a resident identified as having a significant increase in their care and support needs, did not have their care plan reviewed or updated to reflect these significant changes. As a result, the care plan did not provide person-centred guidance on how to safely and effectively meet the needs of the residents. Furthermore, inspectors found that the needs of residents were not always known to the staff, and this resulted in residents not always receiving care and support in line with their assessed needs and care plans.

Through a compliance plan submitted following a previous inspection of the centre, the provider had committed to implementing systems to monitor residents' health care needs on a daily basis to ensure timely access to health care professionals for expert assessment. However, inspectors found that this system was not operating effectively resulting in a failure to ensure appropriate clinical oversight and timely access to health care professionals. Where some residents had been referred for further expert assessment, the recommendations made by health care professionals were not always implemented in a timely manner. This impacted on the quality of care provided to residents.

While there was safeguarding systems in place to protect residents from abuse and a policy that detailed the organisations approach to safeguarding vulnerable people, inspectors found that the provider did not ensure that safeguarding incidents were managed appropriately, in accordance with the centre's safeguarding policy. This is a repeated finding from the previous inspection.

A review of the nutritional aspects of the service found that the provider did not have robust arrangements in place to manage nutritional risk or monitor the nutritional care needs of residents. While nutritional screening was in place for all residents, the care pathway for residents assessed as being at risk of malnutrition was not consistently implemented. In addition, residents did not always receive nutritional care and support in line with their nutritional care plans.

A review of the fire safety systems in the centre found that some action had been taken by the provider to address issues relating to fire safety, identified in the provider's own fire safety risk assessment completed in 2024. There were systems in place to ensure that fire detection and emergency lighting were maintained at scheduled intervals. However, inspectors found that the provider had failed to complete all requisite fire safety works within the time-lines submitted to the Chief Inspector, that date being 31 December 2024. This included fire containment works

to compartment walls, fire doors and the kitchen area. Consequently, the physical environment did not ensure that residents were protected from the risk of fire.

Residents reported that the quality of the information shared with them did not enable them to fully participate in the organisation and planning of the service. For example, residents were aware that one staff member allocated to provide activities was on planned leave, leaving only one staff member to provide activities for a significant number of residents. However, they had not been formally informed of this change or how it might impact the daily activities they received.

While there was an activity schedule in place, residents were not always provided with activities in accordance with their interests and capacities. A review of activity records showed that there were limited opportunities for social engagement for some residents.

Regulation 18: Food and nutrition

Residents' food and nutritional care did not fully meet the requirements of the regulations. For example;

- Residents' dietary needs were not consistently met, as prescribed by health care professionals. Some residents were prescribed a diet consisting of small and frequent meals throughout the day. The nutritional care records for those residents did not evidence that nutritional care was provided in line with the resident's assessed needs or care plan. Consequently, the dietary needs of some residents were not being met.
- Residents were not appropriately supervised during mealtimes. For example, two residents required the supervision of staff when eating and drinking. Inspectors observed those residents to be unsupervised during meal-times.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had failed to ensure that residents were protected from the risk of fire, and that actions committed to by the provider in the fire safety risk assessment action plan were completed.

- Fire containment works had not been completed in relation to compartment walls, replacement of external doors, repairs to a number of internal fire doors, service penetrations throughout the building, the installation of fire rated construction around kitchen extracts, and the installation of fire rated attic hatches.

- Fire containment was also compromised as fire doors were held open using items of furniture and equipment.

This is a repeated non-compliance from a previous inspection of the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the residents assessments and care plans found that the registered provider had failed 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, a care plan, based on an accurate assessment of a resident's skin integrity, was not in place for a resident with a pressure ulcer. 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. For example, a care plan had not been updated to reflect a significant deterioration in a residents mobility care needs and their increased dependency on staff for support.
- 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, supervision at mealtimes, and specific one-to-one activities to support the management of their complex behaviours, 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 is evidenced by a failure to;

- provide a resident with timely and appropriate access to health care professionals for further assessment and expertise when clinically indicated, in line with the centre's policies, associated procedures, and the recommendation of the health care professional in the event of further deterioration. For example, a resident at risk of malnutrition was not referred

for further expert assessment and review despite further weight loss, in line with the recommendations of health care professionals and their nutritional management plan.
- provide a resident with timely access to necessary health care treatment following recommendations made by health care professionals. For example, adequate arrangements were not in place to ensure the timely assessment and response to residents' deteriorating clinical status and pressure ulcer care to ensure the recommendations of health care professionals were implemented in a timely manner.
- ensure arrangements were in place to implement the recommendations and interventions prescribed by health care professionals following expert assessment. For example, the recommendations made following assessment by dietitian and tissue viability nursing experts were not appropriately implemented. This included monitoring of residents nutritional intake, and ensuring appropriate management of a resident with impaired skin integrity.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 8: Protection

The provider had not taken all reasonable measures to ensure residents were protected from the risk of abuse. This was evidenced by a failure to;

- ensure safeguarding plans, designed to protect residents from the risk of abuse, were appropriately implemented. For example, residents who required enhanced levels of supervision to ensure their safety and the safety of others did not consistently receive this supervision.
- 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: Substantially compliant

Regulation 9: Residents' rights

Residents were not provided with adequate opportunities to participate in activities that reflected their individual capacities and preferences. Residents who required the provision of person-centred activities as a therapeutic intervention to support the management of their complex care needs were not provided with such activities. Furthermore, some residents reported that they had limited access to activities and

attributed this to there being inadequate staff available to provide social care. This was observed by inspectors, and confirmed by staff and through a review of the relevant records.

Residents stated that they were not consulted about matters within the centre that had the potential to impact on them. Closed Circuit Television (CCTV) had been installed in the centre without any prior engagement or communication with residents, meaning they were not informed of, nor given an opportunity to express their views on this significant change to the lived environment of the resident.

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	Not 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	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0047396

Date of inspection: 09/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

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

• Active recruitment is underway to fill vacancies in the kitchen staff rota
• A workforce plan is being developed by HR to track, analyse and plan for planned and short notice vacancies across all departments
• Agency kitchen staff were organized immediately post the inspection
• A third activities co-ordinator is being recruited to provide for 2 staff members over 7 days and facilitate periods of planned leave
• Two Clinical Nurse Managers have been recruited to enhance the level of clinical and daily supervision of staff covering 7 days. Commencement dates are scheduled for September 29th and October 13th.
• Residents' assessed needs are reviewed on a weekly basis using a validated nursing tool and staffing rosters are adjusted in line with changes in residents' status, occupancy of the centre and planned/ unplanned leave
• Minimum staffing levels are being drafted for each department with guidelines on how these could be adjusted in line with validated nursing assessment tools and changes in occupancy to ensure there is no ambiguity where adjustments to the normal roster are required
• Senior nurse managers will now supervise/ assist at each meal on both floors to enable allocated healthcare assistants to respond to call bells so that staff assisting residents eating in their rooms are not disturbed
• Call bell audits will now occur on a weekly basis and trends in call bell activation times and response times will be monitored to ascertain the staffing demands at different times of the day
• Resident satisfaction surveys in relation to staffing levels and activity provision will now be conducted on a monthly basis and will be tabled at each Residents' Committee meeting as standard agenda items

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 16: Training and staff development	Not Compliant

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

• Each staff nurse has been reminded that they are professionally accountable for ensuring that residents under their care receive care and support in line with their assessed needs and as outlined in their individual care plan. Each nurse on duty will therefore monitor that healthcare assistants (HCAs) are providing the care and support on a daily basis to include a review of HCA electronic record entries.
• The acting PIC will review on a daily basis all residents (with a known high/ very-high clinical risk) to ensure that their assessments and care plans are up-to-date and that there is documented evidence that care is being delivered as required. This includes all residents who have been seen by a medical or allied health professional in the previous 24hrs to ensure that their recommendations (such as diagnostic tests) are being implemented in a timely manner.
• We are actively recruiting to enhance the clinical oversight of the centre to include a new Person in Charge and 2 Clinical Nurse Managers (both commencement dates have been scheduled). In addition, a new Clinical Operations Manager has commenced in post from 01 September 2025 working full-time in the centre. Her role is to provide on-the-floor mentorship, training, guidance and support to staff nurses and healthcare assistants to ensure that all residents are actively supervised, supported and their assessed needs are consistently met on a daily basis. She is therefore actively supervising staff allocations and ensuring that staff supervision arrangements are in place as required. She also monitors residents' clinical documentation on a daily basis as part of this oversight arrangement.
• Activities co-ordinators are now allocated to each floor (communal areas) to ensure group activities are taking place while healthcare assistants are still engaged in providing personal care to individual residents. One-to-one activities provision (previously scheduled early morning) has now been moved to a later time in the day when the majority of residents have had their daily personal care needs met and are out of bed.
• A new Out-of-hours Clinical supervisor commenced on 28 July 2025. Her role includes conducting unannounced evening and night-time spot checks, staff training and reviews of care plans and documentation.
• A process to complete individual staff competency and appraisals will commence for all staff from September 08th.
• Staff have been reminded of their fire training and the centre's policies and procedures (highlighting the practice of wedging doors) via a staff meeting held on August 06th. Walkarounds by the Acting PIC and the Clinical Operations Manager will oversee the implementation of this in practice.
• Mock inspections by an independent nurse consultant had commenced post-inspection on a monthly basis (both in-person and online review of residents' records). In addition to general compliance these mock inspections will provide independent oversight of the

level of supervision in place through a retrospective review of daily healthcare assistant and activities records. In addition, these will focus on specific key performance indicators to evidence that correct levels of supervision and care are in place. For example, unwitnessed falls, development of pressure ulcers or incontinence-associated dermatitis.

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 communication has issued to all HCAs to remind them that care entries must be contemporaneous and 'live,' and entered as close to the time that care has been delivered as possible.
• Staff nurses on duty in each unit will monitor that care is being delivered by the HCAs and that there is documented evidence of same.
• Daily retrospective spot checks of repositioning records, food and fluid intake/ output and safety checks are now also being downloaded and reviewed each morning by the Clinical Operations Manager to ensure records are complete, accurate and contemporaneous. Any deficits will be brought to the attention of the individual staff member and the supervising nurse on duty, utilizing human resources procedures as required.
• Weekly audits of assessments and care plans for residents at high risk of impaired skin integrity, malnutrition or behaviours that challenge will be conducted by the senior nurse management team (Acting PIC, CNM and Clinical Operations Manager) and will also now form a specific feature of independent mock inspections.
• Rosters are now updated daily and a new roster printed off from the electronic register each morning to ensure hard copy rosters displayed reflect the true worked roster

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:

Significant actions have been taken to strengthen the management structure, staffing resources, and oversight systems in order to ensure that residents consistently receive safe and person-centred care.

Leadership Appointments:

• A letter of offer has issued to a new Person in Charge (PIC) and we are awaiting confirmation of a start date.

• A new Clinical Operations Manager commenced on 1 September 2025, dedicated solely to Droimnin Nursing Home. This role provides on-the-floor daily supervision, coaching, mentoring, and training of all staff.

• A new Out-of-Hours Clinical Supervisor commenced on 28 July 2025, to provide additional oversight, support, and escalation pathways during evenings, nights and weekends.

Governance Strengthening:

• An updated governance document is being developed to clearly define the individual management responsibilities of the senior nurse management team.

• Weekly Senior Clinical Management Team meetings now track the progress of all actions committed to in compliance plans, including urgent compliance plans, to ensure timely and effective implementation.

• Independent mock inspections have been commissioned on a monthly basis to provide external assurance and identify areas for ongoing improvement.

Workforce Planning and Recruitment:

• Active recruitment is underway to fill vacancies in the kitchen staff rota, and agency kitchen staff were organised immediately following the inspection to ensure continuity of catering services.

• A third Activities Co-ordinator is being recruited to allow for two staff to be available across seven days, providing cover during planned leave.

• HR is developing a workforce plan to track, analyse, and plan for both planned and unplanned vacancies across all departments.

• Unplanned leave or absence is now escalated daily to the Group Clinical Director, COO, and HR Manager to ensure timely tracking, analysis, and individualised responses so that sufficient staffing resources are always available to meet resident needs.

Risk Assessment and Oversight:

• A full assessment of workforce-related risks, including supervision deficits and skill mix, has been undertaken and control measures are being implemented.

• Residents' assessed needs are reviewed weekly using a validated nursing tool. Staffing rosters are then adjusted under Senior Group Management direction in line with residents' changing status, centre occupancy, and planned/unplanned leave.

Communication and Supervision Systems:

• Shift handovers have been restructured to ensure all residents with high-risk needs (e.g., skin integrity, falls, malnutrition) are highlighted.

• All residents requiring enhanced monitoring (repositioning, safety checks, mealtime supervision) are flagged on handover sheets.

• CNM verifys that critical information has been communicated during handovers and

documented in daily reports, and senior management are conducting frequent spot checks on handover quality.
• Daily handovers to Healthcare Assistant staff commenced immediately following the inspection to ensure all staff are aware of residents' assessed needs and daily interventions.
• Safety huddles in respect of high clinical risk areas commenced on 1 September 2025.
• Staff meetings have been scheduled to provide regular feedback on performance and care standards.
Healthcare Professional Referrals and Implementation:
• All outstanding referrals were reviewed and actioned immediately after the inspection. Nurses in charge now confirm daily that any residents requiring referral to medical or healthcare services are escalated.
• Recommendations from healthcare professionals (TVN, dietician, physiotherapist) are transcribed into care plans on the day of review and highlighted at handover.
• A weekly audit, completed by the CNM/Clinical Operations Manager, ensures timely implementation and follow-up of all new healthcare recommendations.
Performance Management and Development:
• A process to complete individual staff competency assessments and appraisals commenced on 8 September 2025.
• These appraisals, combined with daily on-floor supervision by the Clinical Operations Manager, will provide continuous oversight, training, and performance monitoring.

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	Substantially Compliant

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

• Daily handovers to Healthcare Assistant staff commenced immediately following the inspection to ensure that relevant staff are aware of residents' assessed needs and daily interventions required to reduce known risks.
• Senior nurse managers will now supervise/ assist at each meal on both floors to enable allocated healthcare assistants to respond to call bells so that staff assisting residents eating in their rooms are not disturbed
• Staff nurses on duty on each unit are now monitoring that care is being delivered to meet residents' assessed nutritional needs and that an accurate and contemporaneous records is maintained on a daily basis.
• Daily retrospective spot checks of food and fluid intake/ output for residents at high

risk of malnutrition are now being downloaded and reviewed frequently by the Clinical Operations Manager to ensure the residents receive their prescribed diets and records are complete and accurate. Any deficits will be brought to the attention of the individual staff member and the supervising nurse on duty, utilizing human resources procedures as required.

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 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Significant progress has been made in addressing the identified risks and ensuring that residents are protected from the risk of fire.

• Ongoing works have been carried out on the compartment walls on the first floor, service penetrations on the ground floor, and the kitchen duct service penetrations. These works are scheduled to be fully completed before the 30/09/2025.
• The service penetrations for the plant room have been completed.
• Fire doors have been repaired across the centre, with all high-risk fire doors (including bedroom doors) repaired. Of the total 79 doors, repairs have been completed on the high-risk set, with 15 doors remaining for auxiliary rooms. These remaining repairs will be completed by 15/10/2025.
• An automatic opening vent has been installed in the stairwell, and fire rating works have been completed on the roof window enclosures.
• Repairs and upgrades to all emergency lights have been completed.
• Replacement of fire-rated attic hatches is scheduled and will be completed before the end of 30/11/2025.
• The gas tanks have been relocated to a further distance from the building work is complete.
• The evacuation footpath at the back of the building has been extended and work is complete.
• Daily inspections of escape routes and fire doors are in place and completed by maintenance personnel. This will be overseen by the senior nurse managers daily and Clinical Supervisors during day and night-time.

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:

• Weekly audits of assessments and care plans for residents at high risk of impaired skin integrity, malnutrition or behaviours that challenge will be conducted by the senior nurse management team (Acting PIC, CNM and Clinical Operations Manager) and will also now form a specific feature of independent mock inspections. Findings will be shared with the RGN Team, discussed and actioned immediately. Audit outcomes are also reviewed at weekly governance meetings, with Regional Clinical Director oversight.
• A staff meeting occurred on August 06th to remind staff of the need to update care plans following any change in the resident status or reassessment by medical or allied health professionals. This will be overseen daily by senior nurse managers and clinical supervisors and reviewed as part of the independent mock inspections.
• A process to complete individual staff competency and appraisals will commence for all staff from September 08th. Staff performance in assessment and care planning will be a key focus of these competency assessments and appraisals and additional training will be arranged for staff as required.
• Daily handovers to Healthcare Assistant staff commenced immediately following the Inspection to ensure that relevant staff are aware of residents' assessed needs and daily interventions required to reduce known risks.
• Each staff nurse has been reminded that they are professionally accountable for ensuring that residents under their care receive care and support in line with their assessed needs and as outlined in their individual care plan. Each nurse on duty will therefore monitor that healthcare assistants (HCAs) are providing the care and support on a daily basis to include a review of HCA electronic record entries.
• All residents assessed as requiring enhanced supervision are now clearly identified on handover sheets.
• Residents requiring frequent skin checks and repositioning have been placed on clearly defined schedules (documented in Epic). Nurses in charge review compliance each shift.
• A mealtime supervision roster has been introduced to ensure residents requiring assistance are supported consistently. Supervisory roles are allocated at each handover.
• Residents with care plans requiring specific one-to-one activities to support complex behaviours now have scheduled activity plans, which are documented in Epic and verified by activity staff and the nurse in charge.
• Daily retrospective spot checks of repositioning records, food and fluid intake/ output and safety checks are now being downloaded and reviewed frequently by the Clinical Operations Manager to ensure records are complete, accurate and contemporaneous. Any deficits will be brought to the attention of the individual staff member and the supervising nurse on duty, utilizing human resources procedures as required.
• Dedicated refresher training on assessment and care planning will be completed by the Clinical Operations Manager for all Nurses arranged to commence September 08th.

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:

• Refresher training has been arranged for nursing staff on assessing and managing the risk of malnutrition, impaired skin integrity and the assessment and management of wounds, including the need for specialist input/ referral. This will be ongoing until all nurses are captured.
• Residents at risk of malnutrition or impaired skin integrity will be a key focus of independent mock inspections and in-house day and out-of-hours clinical supervision.
• The acting PIC will review on a daily basis all residents (with a known high/ very-high clinical risk) to ensure that their assessments and care plans are up-to-date and that there is documented evidence that care is being delivered as required. This includes all residents who have been seen by a medical or allied health professional in the previous 24hrs to ensure that their recommendations (such as diagnostic tests) are being implemented in a timely manner.
• Senior nurse managers will actively supervise all wound dressings to ensure recommended treatment is provided in a timely manner, that wound assessments are completed thoroughly and that residents are referred to specialist allied health services as required.

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	Substantially Compliant

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

• All staff have now received updated training in recognizing and responding to allegations of abuse.
• Each staff nurse has been reminded that they are professionally accountable for ensuring that residents under their care receive care and support in line with their assessed needs and as outlined in their individual care plan. Each nurse on duty will therefore monitor that healthcare assistants (HCAs) are providing the care and support on a daily basis to include a review of HCA electronic record entries.

• Daily retrospective spot checks of safety checks are now being downloaded and reviewed each morning by the Clinical Operations Manager to ensure that residents who require enhanced supervision receive this as per their assessed frequency and that records are complete, accurate and contemporaneous. Any deficits will be brought to the attention of the individual staff member and the supervising nurse on duty, utilizing human resources procedures as required.

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:

• A third activities co-ordinator is being recruited to provide for 2 staff members over 7 days and facilitate periods of planned leave
• Activity provision has been supplemented with organized activities provided by external professionals and will be reviewed in consultation with residents
• A full review of residents' assessed needs and stated preferences for hobbies/ activities has been conducted using information from each residents' 'A Key to Me' assessment to ascertain individual and shared areas of interest. This information has been utilized to immediately schedule new activities and redraft a proposed new activity planner which will be presented to and discussed with residents at the next Residents' Committee meeting to be held on September 10th.
• All proposed changes to the centre will now be listed on the Residents' Committee Meeting agenda and fully discussed with residents in advance of any works commencing.
• Resident satisfaction surveys in relation to staffing levels and activity provision will now be conducted on a monthly basis and will be tabled at each Residents' Committee meeting as standard agenda items

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	30/06/2025
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff,	Substantially Compliant	Yellow	10/07/2025

	based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	01/09/2025
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	17/09/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2025
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,	Not Compliant	Red	30/06/2025

	specifies roles, and 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	Red	30/06/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/11/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2025
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).	Substantially Compliant	Yellow	31/10/2025

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.	Not Compliant	Orange	12/09/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/10/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais	Not Compliant	Orange	31/10/2025

	from time to time, for a resident.			
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	15/09/2025
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	26/09/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	08/09/2025
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	01/09/2025
Regulation 9(2)(b)	The registered provider shall provide for residents	Not Compliant	Orange	16/09/2025

	opportunities to participate in activities in accordance with their interests and capacities.			
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.	Not Compliant	Orange	17/07/2025