



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Athlunkard House Nursing Home
Name of provider:	Athlunkard Nursing Home Ltd
Address of centre:	Athlunkard, Westbury, Clare
Type of inspection:	Unannounced
Date of inspection:	17 June 2025
Centre ID:	OSV-0000729
Fieldwork ID:	MON-0047426

About the designated centre

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

Athlunkard House is a modern purpose built two-storey purpose nursing home. It can accommodate up to 103 residents. It is located in a residential area in Co. Clare on the outskirts of Limerick city. It is situated close to many amenities including St. Nicholas church and a local shopping centre. Athlunkard house accommodates male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older persons who require general nursing care, dementia care, physical and intellectual disabilities, palliative care, respite and post-operative care. Bedroom accommodation is provided on both floors in 89 single and seven twin bedrooms. All bedrooms have en suite bathroom facilities. There is a lift provided between floors. There is a variety of communal day spaces provided including a dining room, day room and visitors rooms provided on each floor. Residents also have access to two secure enclosed garden areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	93
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 17 June 2025	07:50hrs to 16:10hrs	Sean Ryan	Lead
Tuesday 17 June 2025	07:50hrs to 16:10hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

In general, residents living in Athlunkard House Nursing Home told inspectors that the quality of care and support they received from staff was of a satisfactory standard. While most residents were satisfied with the quality of social care, some residents who spent more time in their bedrooms told inspectors that they would welcome more person-centred activities.

Inspectors arrived unannounced at the centre in the morning, during the handover period between night and day staff. During this time, inspectors listened to the exchange of information between shifts regarding residents' care needs. Inspectors were met by an assistant director of nursing. Following a brief introductory meeting, inspectors met with residents and spent time observing the quality and safety of care being provided in both the dining rooms and communal day rooms.

There was a warm and welcoming atmosphere in the centre which was apparent to the inspectors on arrival. While some staff were preparing to receive handover, others were assisting residents who had chosen to get up early and make their way to the dining room for breakfast. A staff member was assigned to the dining area and was observed attending to residents needs, offering tea, coffee and juices, and taking time to ask each resident what they would like for breakfast. One resident told inspectors that they enjoyed getting up early to have breakfast with other early risers who they had come to know. They shared that they valued this quiet time and the familiar company before the dining room became busy later in the morning.

Inspectors walked through the centre and observed staff preparing to assist residents with their morning care. Corridors were well-organised and equipped, with linen trolleys stocked with fresh linen in place and ready for use. Residents were observed engaging in a variety of morning routines. Some were in their bedrooms enjoying breakfast, reading the morning paper, listening to the radio, or watching television. Others were seen walking through the centre and along corridors chatting to staff they met along their way.

Inspectors spoke with residents in communal areas and in their bedrooms. They generally expressed satisfaction with the care they received. They described their bedrooms as their own personal space, which they were encouraged to personalise. Each room had adequate storage for personal belongings, television and call bell facilities. Some residents had personalised their bedrooms with items to create a more homely and comfortable environment. These personal touches included soft throws, cushions and additional seating.

Residents reported that staff were generally attentive to their needs and responded to call bells with minimal delays, except during periods when staff were occupied assisting other residents. Inspectors observed that in some instances call bells were not positioned within easy reach of residents, limiting their ability to request assistance when needed. Despite this, staff were seen routinely walking through

corridors and checking on residents in their rooms which provided opportunities for residents to request help directly. Conversations with staff and management revealed that staff carried pagers that alerted them to the location of a call bell activation. However, there was a limited number of pagers available and not all care staff had access to one. This is discussed further under Regulation 9, Residents' rights

Throughout the day, residents were observed participating in a variety of structured activities including both chair-based and mobility-focused exercises, as well as music and singing. These activities were facilitated on both floors in the communal areas. Staff were observed engaging with residents and supporting them to take part. However, no activities were provided to residents who chose to remain in their bedrooms. A number of these residents told inspectors that they did not enjoy group settings or large gatherings and preferred instead to spend time alone in their bedroom. Nonetheless, they told inspectors that they would welcome opportunities for one-to-one engagement or individualised activities tailored to their preferences. The activities programme observed by the inspectors did not include provisions for one-to-one activities for resident who did not participate in group activities.

Some residents were aware of the procedure for raising a concern or making a complaint and stated they could also raise concerns at scheduled resident meetings. A number of residents commented on the quality of the food and that it had not always been to their liking. They reported having raised the issue with staff in the past. While they did not receive direct feedback or a response, they observed the quality of food has since improved which they attributed to their concerns being taken into consideration.

Inspectors spoke with five visitors throughout the day of inspection. Visitors were complimentary of the care provided to their relatives and felt that they never felt restricted in terms of visiting. Visitors said that they were aware of how to raise a concern or make a complaint.

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 risk 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).
- review the implementation of quality improvement actions committed to by the provider within a provider assurance report requested by the Chief inspector, following monitoring notifications pertaining to the safeguarding and protection of residents from abuse.

- review a compliance plan submitted by the provider to address the non-compliant issues identified during the previous inspection in October 2024.
- Review unsolicited information received by the Chief Inspector. The information received pertained to concerns regarding the governance and management of the centre, the systems in place to safeguard and protect residents, the supervision of staff, complaints management, and resident's access to timely health care. This information was substantiated on this inspection.

This inspection found that the specific roles, responsibilities, and accountability of the clinical management team in relation to the supervision and oversight of the service were not clearly defined, particularly in relation to safeguarding, risk management, staff training and supervision and the management of complaints. As a result, the governance and management did not ensure that effective management systems were in place to ensure the service provided was appropriate, consistent and effectively monitored.

Athlunkard Nursing Home Limited is the registered provider of Athlunkard House Nursing Home. The provider is part of the Emeis group, which has a number of other designated centres within Ireland. This inspection was carried out following the airing of an RTE Investigates programme in June 2025 showing concerning practices in respect of the provision of care to vulnerable residents in two other designated centres in the Emeis group.

Athlunkard Nursing Home Limited is a company consisting of four directors, one of whom represents the registered provider. A senior regional management structure was also in place. A regional director and associate regional director were persons participating in the management of the centre. They were responsible for monitoring clinical and operational aspects of the service, in addition to providing oversight and governance support to the person in charge through a weekly presence in the centre.

Within the centre, the person in charge was supported in both administrative and clinical functions by two assistant directors of nursing and a team of clinical nurse managers. 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 always ensure that delegated areas of responsibility were being effectively monitored, as systems to manage risk, records and complaints were not consistently implemented in practice.

Clinical and environmental audits were completed on an electronic system. There was a comprehensive audit schedule in place and audits were completed in line with this schedule. However, a review of a sample of audits found that while issues of risk and quality improvement were being identified, and appropriate actions had been assigned to staff, some issues had not been identified by the auditing system and therefore no action had been taken. For example, a recent care plan audit did not identify that some care plans were generic and not person-centred.

The systems in place to safeguard and protect residents were not effective. While there was a safeguarding policy in place that outlined the procedures for protecting residents from the risk of abuse, including the identification of and response to allegations of abuse, this policy was not fully implemented in practice by those responsible for its oversight. For example, concerns received through complaints by the centre that were indicative of potential abuse were not identified as such, and were therefore not appropriately managed when first received. These issues were later identified by senior management during monthly audits and appropriate action was taken at that point. However, the delay in recognising potential safeguarding incidents meant that resident safeguarding plans were not in place from the time the information was initially received, leaving residents potentially at risk in the interim. The delays in recognising potential abusive incidents varied from one week to five weeks from the date the incident occurred.

Notifiable incidents were not always submitted to the Chief Inspector in line with regulatory requirements.

Despite being identified on the previous inspection, the management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a supportive and effective manner. A complaint received from another health care facility had not been appropriately reviewed by the personnel responsible for the management of complaints, or escalated to senior management, in line with the centre's own complaints management policy. This impacted on the provider's ability to identify contributing factors to deficits in the quality of the service.

A review of the risk register evidenced that some clinical and environmental risks were assessed and had been categorised according to their level of risk to residents. However, the risk register did not contain some of the known risks in the centre, such as inconsistent access to general practitioner services for residents. The provider had not assessed the potential risks to residents or established the number of residents affected. Consequently, there was no plan in place to appropriately manage the risk and impact to residents.

A review of the centre's staffing roster on the day of inspection found that the staffing levels and skill mix were appropriate to meet the assessed health and social care needs of the residents, given the size and layout of the building. There were sufficient numbers of housekeeping, catering and maintenance staff in place.

Inspectors found that the arrangements in place to supervise and support staff to implement the centre's policies and procedures, and documentation of clinical care records were not effective.

Regulation 15: Staffing

There was sufficient staff with an appropriate skill mix 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.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised. This was evidenced by;

- inadequate supervision of staff allocated to the provision of social care to residents in the centre.
- a lack of oversight of the residents clinical documentation, including the assessment of residents needs and care planning, were accurate and up-to-date.
- the failure to implement the policies and procedures in place to support and protect residents and manage complaints.

Judgment: Substantially compliant

Regulation 21: Records

Records were not managed in line with regulatory requirements. For example;

- A full and completed record of staff training in respect of each person working in the designated centre was not appropriately maintained as required by Schedule 4(8)(c) of the regulations. Up-to-date records to confirm all staff had completed training in relation to safeguarding and protection of residents were not provided for review.
- Records pertaining to money received on the behalf of residents were not appropriately maintained in the designated centre or accessible, as required by Schedule 3 of the regulations. Records of residents individual ledgers were not maintained and up-to-date statements of accounts were not made available for inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The roles and responsibilities of the nurse management team were poorly defined. It was unclear who held responsibility for key aspects of the service, including the oversight of risk management, incidents, complaints and record management. This did not ensure that management systems were being effectively implemented and monitored to ensure effective oversight of the service.

The overall governance and management of the centre was not fully effective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- Ineffective systems in place to safeguard and protect residents as discussed under Regulation 8, Protection. This was compounded by poor implementation of policies and procedures intended to protect residents from the risk of abuse.
- Poor oversight of incidents involving residents to ensure statutory notifications were submitted to the Chief Inspector within the required time frame.
- Inadequate oversight of the complaints management system to ensure that all complaints and concerns were appropriately identified, recorded and investigated in accordance with the complaint management policy and procedure.
- 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 as discussed under Regulation 6, Health care.
- Poor oversight of nursing documentation. A review of the quality of resident's care plan found that care plans were not based on the assessment of residents needs or risks.
- Inadequate oversight of the complaints management system to ensure that all complaints and concerns were appropriately identified, recorded and investigated in accordance with the complaint management policy and procedure
- Inadequate arrangements in place to ensure appropriate supervision and oversight of staff.
- Repeated non-compliance in key regulations that underpin the quality and safety of care provided to residents.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications regarding four incidents of alleged or confirmed abuse of residents were not submitted to the Chief Inspector within the required time-frame.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints log in the centre found that complaints were inconsistently managed in line with the centres' own complaints policy or with the requirements of Regulation 34.

Concerns brought to the attention of the management staff in relation to fall incidents, residents transfers to the acute health care service and food quality had not been appropriately documented, investigated or managed within the centre's complaints register. This meant that there was no record of how these issues were acknowledged, investigated or resolved.

This is a repeated finding from the previous inspection.

Judgment: Not compliant

Quality and safety

On the day of inspection, residents' health and social care needs were maintained to a satisfactory standard of evidenced-based care and support from a team of staff who demonstrated a clear understanding of each resident's individual needs and preferences. However, some residents individual care plans did not reflected their assessed and known care needs. In addition, ineffective systems of governance and oversight as outlined in the capacity and capability section of this report impacted on aspects of the quality and safety of care provided to residents. This included access to health care, the provision of activities, and ensuring residents were adequately safeguarded and protected from harm.

A sample of residents' individual assessment and care plans were reviewed. While it was evident that assessments were being completed and all residents had a care plan in place, the content of some assessments did not fully reflect the residents' actual care needs. Consequently, the care plans did not always clearly or accurately identify the residents current care needs or include person-centred guidance to support the delivery of care.

A review of residents' records showed that residents were not always provided with timely referral and access to general practitioner (GP) services regarding their health care needs, or following early detection of signs and symptoms of physical deterioration. Inspectors also found that residents were not consistently observed or

monitored during the period in which they were receiving treatment, as recommended by a health care professional.

The procedure to safeguard residents was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents should a safeguarding concern arise. However, inspectors found that on occasion appropriate action had not been taken to investigate incidents or allegations of abuse, in line with the centre's own policy.

While there was an activity schedule in place, not all residents were not provided with activities in accordance with their interests and capacities. In addition, some residents were observed to experience extended wait times for assistance with their care needs. This impacted on the dignity and choice.

Residents were provided with information about the services available to support them, including safeguarding and advocacy services. This information was prominently displayed within the centre in an accessible format.

Residents were provided with opportunities to provide feedback on the quality of the service through scheduled resident meetings and through resident surveys.

Regulation 5: Individual assessment and care plan

A review of the residents' assessments and care plans found that they were not fully compliant with the regulatory requirements. For example;

- Residents with complex communication needs did not always have an appropriate or accurate assessment of their needs completed. Consequently, the care plan developed did not detail the interventions necessary to support residents who required support to communicate effectively.
- Care plans relating to residents' social care needs were not person-centred. They were based on a generic template and did not accurately or adequately reflect each residents individual social preferences, interests, or support needs.

This is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were not always provided with appropriate medical and health care including a high standard of evidenced-based nursing care, in accordance with professional guidance.

- Some residents were not provided with timely access to general practitioner services when clinically indicated. For example, a number of residents had not been reviewed by a general practitioner in a period of six months despite showing signs and symptoms of physical deterioration.
- There were inadequate arrangements in place to appropriately monitor residents during prescribed treatment for signs of clinical deterioration.

Judgment: Substantially 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;

- identify and manage a potential safeguarding incident reported to the nurse management team.
- ensure safeguarding plans, designed to protect residents from the risk of abuse, were appropriately implemented. This included actions such as the supervision of staff.

Judgment: Not compliant

Regulation 9: Residents' rights

Some residents were not supported to engage in activities that reflected their individual interests and capacities. In particular, residents who did not wish to participate in group activities were not offered suitable alternatives, resulting in limited opportunities for meaningful engagement in line with their personal preferences and needs.

Some residents experienced extended wait times for assistance when using their call bell due to an ineffective call bell alert system. Not all staff carried pagers linked to the call bell system, resulting in delayed or missed responses to respond to residents requests for assistance. This impacted on residents safety, dignity and right to appropriate and timely support.

This is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Athlunkard House Nursing Home OSV-0000729

Inspection ID: MON-0047426

Date of inspection: 17/06/2025

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>A full review of staff supervision was completed on 13th June 2025 to ensure that staff are supervised appropriately and specifically in the provision of meaningful activities to residents. This includes the allocation of senior health care assistants in a supernumerary capacity to guide and support care staff.</p> <p>By the 31st of August 2025, further training will be provided to the CNMs on their role and responsibility in relation to staff supervision to ensure that staff are appropriately supervised and supported to deliver high standards of care to residents in line with their care needs and personal preferences.</p> <p>Training will be provided by the 31st August 2025 to all nursing staff on clinical documentation requirements including care planning and assessments. This will be reviewed weekly by the DON/ADON to ensure they are reflective of individual resident care needs and up to date. Care planning and assessments will be reviewed monthly by the regional team to ensure they guide staff from 1st of August 2025.</p> <p>From the 1st of August 2025, refresher training on policies and their implementation for nurse managers is underway to ensure all are fully aware of their role and responsibility in ensuring care delivered and the management of complaints is in line with the centre's agreed policies.</p> <p>From the 1st of August 2025, compliance with the above actions will be reviewed by the regional team at clinical governance to ensure actions are implemented on time and improved standards of care are achieved.</p>	
Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
 The training matrix was updated on 30th July 2025 to ensure it accurately identified the training completed by all members of staff. A system is now in place to ensure that this is maintained accurately and this will be monitored by the DON and overseen by the Regional Director.

On the 19th June 2025, resident statements were forwarded to the inspector. Statements are made available to residents at the end of every month reflecting all monies received and paid from resident pension accounts. All records pertaining to monies received are available for review as per our policy- complete

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

The roles and responsibilities of the clinical management team were reviewed on 8th August 2025 and re-defined to ensure there is a clear understanding of each member's responsibility for all aspects of the service, including oversight of risk management, incidents, complaints and record management.

A review of the governance and management systems and training needs are ongoing to ensure improved oversight by the PIC and Regional team of systems and practices in relation to:

- Safeguarding and protection of residents through robust implementation of agreed policies
- Incident management, identifying and dissemination of learning
- Timely notification as per regulatory requirements
- Complaints Management including the recording and investigations of complaints.
- Risk management
- Nursing documentation
- Supervision and oversight of staff.

This review will be completed by 31st August 2025 and from 1st August 2025, bi-weekly oversight of the above areas will be completed by the regional director to ensure that issues are identified, reported and managed in line with agreed policies.

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

By the 31st August 2025, refresher training will be provided to the DON and ADONs in respect of their regulatory responsibilities and the importance of recognizing incidents requiring notification in a timely manner.

By the 31st August 2025, a bi-weekly analysis will be completed by the PIC to ensure all incidents which require notifications are identified and sent within the required time frame and will escalate any non-compliance with this to the RPR.

Regulation 34: Complaints procedure

Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

A review of the current practices in the management of complaints was completed in June 2025.

By 31st August 2025, training will be delivered to all the clinical management team to ensure complaints are identified managed and addressed as per the centre's agreed policy.

From the 1st August 2025 all management of complaints as well as determining if resident feedback has been escalated appropriately will be reviewed by the regional team weekly to ensure required compliance is achieved.

Regulation 5: Individual assessment and care plan

Substantially Compliant

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

A review of resident assessments and care plans is underway to ensure they detail the necessary interventions to support residents. This will be completed and reviewed by the ADON and will be completed by 30th August 2025.

From the 1st August 2025, care plans and assessments will be reviewed bi-monthly by the PIC to ensure that they are person centered and appropriate to meet the assessed needs and preferences of the residents.

From the 1st September 2025, on a monthly basis, the regional director will review a sample of care plans, cross reference with resident assessments and triangulate with staff to provide robust oversight and assurance that care plans are in line with resident needs and guide staff appropriately.

Regulation 6: Health care	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 6: Health care:</p> <p>By the 31st August 2025, a clear procedure will be available to guide staff on the steps to follow when residents require GP review out of the GP's normal working hours or on occasions when the GP is unable to attend the centre.</p> <p>By 30th September 2025, a review will be completed to confirm that all residents will have seen their GP within the last 4 months.</p> <p>By the 31st August 2025, all nursing staff will receive training on the importance of following this procedure.</p> <p>By the 31st August 2025, all nursing staff will receive refresher training on the arrangements in place to appropriately monitor residents during prescribed treatment. By 30th September 2025, a review will be completed to ensure that any training needs by nurses have been identified and addressed and/or that any performance management required is addressed.</p> <p>From the 1st August 2025, the regional director will review GP attendance at the centre, resident monitoring and nurse compliance with the escalation procedure, at the monthly governance meeting to ensure that further improvements required are identified and addressed in a timely manner.</p>	
Regulation 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <p>The Director of Nursing and the assistant director of nursing are registered to attend HSE safeguarding designated officer training. This will be completed by the 31st August 2025</p> <p>By the 30th September 2025, all clinical management will receive refresher training on safeguarding to include their roles and responsibilities in identifying and managing a potential safeguarding incident.</p> <p>By the 31st August 2025, all safeguarding care plans will be reviewed and updated to provide assurance that they appropriately address the identified risk of abuse.</p> <p>By the 5th September 2025, all staff will receive training sessions on the required actions outlined in all resident safeguarding care plans. This will be monitored by the Assistant Director of Nursing weekly to ensure all aspects of the safeguarding care plans are understood and delivered by staff.</p> <p>From the 1st September 2025, on a monthly basis, the regional director will review a sample of safeguarding care plans, cross reference with the identified risk of abuse and</p>	

triangulate with staff to provide robust oversight and assurance that care plans are in line with resident needs and guide staff appropriately.

Regulation 9: Residents' rights

Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
By the 31st August 2025, a re-assessment of residents needs and preferences will be completed to ensure that all residents are supported to engage in activities that reflect their individual interests and abilities which include both group and one to one activities. By the 30th September 2025, The PIC will complete a monthly analysis on the activities provided and documented to ensure they meet residents individual interests and abilities, This includes a review of issues raised at resident council meetings, Cameo cafés, annual satisfaction surveys as well as a review of the management walkabout documentation. Additional pagers have been ordered to ensure that all staff carry a pager linked to the call bell system. Expected delivery is the 31st August 2025

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/08/2025
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.	Substantially Compliant	Yellow	30/07/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	19/06/2025
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	Substantially Compliant	Yellow	08/08/2025

	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	31/08/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	31/08/2025
Regulation 34(3)	The registered provider shall take such steps as are reasonable to give effect as soon as possible and to the greatest extent practicable to any improvements recommended by a complaints or review officer.	Substantially Compliant	Yellow	31/08/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on	Not Compliant	Orange	31/08/2025

	foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
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.	Substantially Compliant	Yellow	31/08/2025
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.	Substantially Compliant	Yellow	31/08/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under	Substantially Compliant	Yellow	31/08/2025

	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 from time to time, for a resident.			
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Substantially Compliant	Yellow	31/08/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/09/2025
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	31/08/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	31/08/2025
Regulation 9(2)(b)	The registered provider shall provide for	Substantially Compliant	Yellow	30/09/2025

	residents opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/08/2025