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An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

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

## Issued by the Chief Inspector

Name of designated centre:	Waterford Residential Care Centre
Name of provider:	Health Service Executive
Address of centre:	St Patrick's Way, Waterford, Waterford
Type of inspection:	Unannounced
Date of inspection:	13 November 2025
Centre ID:	OSV-0007792
Fieldwork ID:	MON-0048171

## About the designated centre

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

Waterford residential care centre is a new purpose built centre set out over two floors. It is built to a high specification and consists of two units of 30 beds and one unit of 20 beds, providing a total of 80 beds. The units were named after local Waterford areas surrounding the centre. Ferndale unit has 30 continuing care beds, Farronshoneen ward has 29 continuing care beds and 1 respite bed, and Grange has 20 continuing care beds. All of the bedroom accommodation is provided in single ensuite bedrooms. There are a number of sitting room and dining rooms in each of the units and additional multipurpose rooms including activity rooms and quiet/visitor rooms. The variety of communal spaces provided adequate space and choice for residents. There were also other areas along corridors with seating for use by residents. Facilities shared between all units include a large function room, a tranquil room, a hairdresser room, a treatment room, laundry, meeting rooms, overnight room for families, offices, visiting areas and a number of secure outdoor areas. Residents and families also have access to large communal area's near the entrance and in the atrium of the building.

Waterford Residential Care Centre provides 24 hour care for Female & Male residents who require various levels of nursing care from continuing care, rehabilitation and respite care. There is a good ratio of nurses on duty during the day at night time. The nurses are supported by care, catering, household and activity staff. Medical and allied healthcare professionals provide ongoing healthcare for residents.

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

Number of residents on the date of inspection:	78
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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
Thursday 13 November 2025	09:05hrs to 17:55hrs	Aisling Coffey	Lead
Friday 14 November 2025	08:00hrs to 16:15hrs	Aisling Coffey	Lead
Thursday 13 November 2025	09:05hrs to 17:55hrs	Sinead Corbett	Support
Friday 14 November 2025	08:00hrs to 16:15hrs	Sinead Corbett	Support

## What residents told us and what inspectors observed

Overall, residents reported being content living in Waterford Residential Care Centre; however, some factors, including food and activity provision, were negatively impacting their day-to-day lives in the centre, as outlined in this report.

The residents spoken with were complimentary of the centre, the staff and the care received. Residents spoke favourably about the centre, describing it as "so homely", "first class" and saying it "couldn't be better". Residents expressed their satisfaction with the standard and size of the available bedroom accommodation. Residents were complimentary about the care they received, describing how they were "so well looked after". Residents were predominantly positive about the kind and considerate staff who cared for them, with the majority of staff being described as "very nice" and "lovely". While praising the staff overall, two residents informed the inspectors of concerns regarding the conduct of one staff member. These matters were referred to the person in charge, who engaged with the residents concerned following the inspection, and submitted the required notifications in respect of their investigations to the Office of the Chief Inspector.

This unannounced inspection was conducted by two inspectors of social services over two days. During the inspection, the inspectors spoke with many residents and engaged in detailed conversations with 19 residents and three visitors to gain insight into the residents' lived experiences in the centre. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

The designated centre is purpose-built, designed and laid out to a high specification. The centre is located on premises that also house rehabilitation and mental health services for older people. The centre is set out across two floors, accessible by stairs, a passenger lift and a designated evacuation lift. The ground floor contained a large production kitchen which catered for all service users within the premises. There are also adjacent laundry facilities on the ground floor, while the first floor contains staff changing and meeting facilities.

Residents' accommodation was set out in two separate 30-bedded units, called Ferndale and Farronshoneen and one 20-bedded unit, called Grange. The units are named after local Waterford townlands. Ferndale is on the ground floor and both Farronshoneen and Grange are on the first floor. The main door to the premises was open, leading to a reception area. From the reception, one travels through a corridor to the café area, where many activities and socialising take place. Ferndale is adjacent to the café area, as is the staircase and lift leading to Farronshoneen and Grange.

Each of the three units has locked doors controlled by an electronic keypad lock. Inspectors noted that the keypad code was not displayed to facilitate residents who

had decision-making capacity and wished to leave their unit independently to attend social activities in the ground-floor café area or use the ground-floor prayer room.

Bedroom accommodation comprised 80 single rooms, each with en-suite facilities, including a shower, toilet, and wash-hand basin. The bedroom accommodation was ample, and the layout was appropriate for residents' needs. Bedrooms had comfortable seating and were personalised with items from home, such as family photographs and artwork. The bedrooms had a television, locked storage, and call-bell facilities. However, on the second morning of the inspection, the inspectors reviewed call-bell access and found that two residents did not have access to their call bells, meaning they could not summon assistance if required. These findings were brought to the attention of the nurse managers, and the staff promptly rectified these matters.

In terms of communal space, on Ferndale and Farronshoreen there were two sitting rooms, two dining rooms, an activities room, and a family/visitors room in each unit. While on Grange, there was one sitting room, one dining room, an activities room and a family/visitors room. The family/visitors room on Grange was observed to be operating as a staff office on the day of the inspection.

The activity rooms on all three units were seen to contain working electric cooker facilities. While acknowledging the potential benefits to residents from participating in cookery activities, further assurances were required that the accessibility of the cooker facilities had been risk-assessed and was operating in line with the provider's fire safety procedures and commitments made to the Chief Inspector, as discussed under Regulation 28: Fire precautions.

Outside the three units, there was a ground-floor café area, where activities were observed taking place over the course of the inspection days. There was a hairdressing salon adjacent to the café. The hairdresser was also on-site on the first inspection day, and residents proudly displayed their new hairstyles. Residents also used a ground-floor prayer room for quiet reflection. The inspectors observed that the doors to the prayer room could not be opened independently by residents seeking to enter or exit the room if they were using a mobility aid. A resident informed the inspectors that the doors were commonly held open with a door stop to allow entry and exit.

The centre was found to be very inviting and pleasantly decorated throughout, providing a comfortable and homely atmosphere. Photographs of residents and staff enjoying group activities and outings were displayed alongside photographs from Waterford in the early 1900s. Professional and residents' artwork was displayed on the walls. While the premises were very clean and maintained to a good standard, some aspects, particularly the maintenance of several doors, required improvement, as discussed under Regulation 17: Premises.

In terms of outdoor space, residents of Ferndale and Grange had access to a courtyard garden within the centre of their units. There was a further courtyard area accessible from the café. These courtyards were clean, tidy, and pleasantly landscaped, featuring raised flower beds, potted plants, decorative ornaments and

outdoor seating. However, the inspectors found uneven and loose paving in two of these courtyard areas, which may pose a risk of falls and injuries to residents.

The inspectors reviewed the kitchen and storage areas throughout the centre. Inspectors found the provider had sufficient stocks of resources, such as food, linen, personal protective equipment and personal care items, including incontinence wear and wipes, to ensure effective care for residents.

Residents could receive visitors in the centre, in communal areas, in the privacy of their bedrooms, or in the designated visitor rooms on Farronshreen and Ferndale. Multiple families and friends were observed visiting their loved ones over the two inspection days.

Residents were complimentary of the activities staff and the activities they provided. However, some residents informed the inspectors that there were occasions when there were insufficient activities taking place. Inspectors found that, while the provider had four whole-time-equivalent (WTE) activity staff, the current organisation of the activities team did not ensure that all residents had an opportunity to participate in activities daily. From reviewing rosters, inspectors found there were occasions when three or four activity staff were on duty together, and other occasions when one activity staff member was on duty.

On the first inspection day, one activity staff member was on duty. This staff member led group activities in the ground-floor café area. 15 residents were seen to enjoy chair-based yoga in the morning, while 14 residents were seen to enjoy a lively game of bingo in the afternoon. While acknowledging the enjoyment these residents experienced from the group-based activities, inspectors noted that there were limited opportunities for social engagement for the residents who did not attend the café and remained in their units. This is discussed further under Regulation 9: Residents' rights. On the second inspection day, there were two activities staff on duty. Nine residents were seen enjoying chair hockey in the café area, while the second activities staff member was engaging in one-to-one and group activities within the units.

The inspectors observed the breakfast, main meal and evening meal over the course of the two-day inspection. Meals were freshly prepared on-site in the centre's kitchen and overseen by the chef. Residents had access to drinking water and other refreshments at meal times and throughout the day. Staff were seen to provide discreet and respectful assistance to residents requiring this support at mealtimes. Residents expressed mixed views on the food served in the centre. While some residents were complimentary and described the food as "lovely", a small number of residents expressed dissatisfaction with the quality of the food available, particularly at the tea-time meal. Other residents expressed their perception that there was limited variation in the meals and desserts provided. This feedback to inspectors aligns with feedback from residents' committee meetings and residents' questionnaires conducted during 2025.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and

how these arrangements impacted the quality and safety of the service being delivered.

## Capacity and capability

While governance and management systems were in place to oversee the quality of care delivered to residents, some improvements were required to ensure the service provided was safe, appropriate, consistent and effectively monitored, as referenced within this report.

This was an unannounced inspection to assess the registered provider's ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and review the registered provider's compliance plan following the previous inspection on 04 September 2024. The inspection informed the provider's application to renew registration. The inspectors also followed up on two pieces of unsolicited information submitted to the Chief Inspector of Social Services regarding staff practices and activity provision. Evidence was found to support the need for action regarding the provision of activities in the three units, as discussed under Regulation 9: residents' rights.

The registered provider had progressed with their compliance plan following the 04 September 2024 inspection; however, two commitments had not been resolved within the provider's timeframes, namely lift evacuation training and replacing privacy screening on some bedroom windows in Grange. This inspection also found that further improvements were required concerning several regulations, including governance and management, as outlined in the report.

The registered provider is the Health Service Executive (HSE). There was a clearly defined management structure which identified lines of accountability and responsibility for the service. The person in charge is responsible for the centre's day-to-day operations and reports to the director of nursing. The director of nursing was a person participating in management. This is a senior manager who supports the person in charge in their operational management and clinical oversight of the centre. This manager was present for both inspection days and supported the inspection process. The director of nursing reports to the manager of older persons' services. This manager represents the provider on regulatory matters and was present at the end of the inspection to receive feedback.

The person in charge worked full-time, five days per week, and was supported by six clinical nurse managers (CNMs), a medical officer, a team of nurses, healthcare assistants, catering, activities, housekeeping, portering, multi-task attendants and administration staff. Deputising arrangements were in place when the person in charge was absent.

The centre was very well-resourced and benefited from services available on campus to enhance the care delivered to residents, including a 0.5 WTE advanced nurse practitioner in dementia and a 0.5 WTE advanced nurse practitioner in tissue viability nursing.

In terms of staff training and development, records reviewed found that staff had access to a suite of mandatory training to support them in their role. Records provided evidenced that staff had completed training on safeguarding vulnerable persons from abuse, fire safety, and manual handling, for example. Notwithstanding this good practice, some gaps in adherence to mandatory training requirements required attention, as did the absence of training for staff in vertical evacuation procedures. These matters are discussed under Regulation 16: Training and staff development.

The registered provider had systems in place to monitor the quality and safety of care. There was documentary evidence of communication between the person in charge, the director of nursing, and the manager of older persons' services. Minutes of these governance meetings found that key aspects of care provision for residents were discussed, including human resources, finance, infection prevention and control (IPC), health and safety, and fire safety. Within the centre, there was evidence of communication between the person in charge and the nurse management team, as reflected in the minutes of CNM meetings, where key issues related to the quality and safety of the service delivered to residents were discussed, including food and nutrition, safeguarding, audit results, and staff training requirements. Records reviewed found the provider had also established several staff committees examining matters including restrictive practice, health and safety, IPC, and fire safety.

The provider had systems to oversee accidents and incidents within the centre. The provider maintained a risk register to monitor known risks. Auditing of key aspects of service provision, such as environmental hygiene, IPC, and medication management, was ongoing. The provider also monitored key performance indicators and produced monthly quality care metrics for wounds, antibiotic use, falls, nutrition and hydration, and restraint use. Notwithstanding this good practice, this inspection found that further robust oversight was required to ensure regulatory compliance. This will be discussed under Regulation 23: Governance and management.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2024. The inspectors saw evidence of consultation with residents and families reflected in the review. In this review, the registered provider had also identified areas requiring quality improvement.

## Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to renew the designated centre's registration in accordance with the requirements in the Health Act 2007 (Registration of

Designated Centres for Older People) Regulations 2015. At the time of inspection, this application was under review.

Judgment: Compliant

### Regulation 15: Staffing

Based on a review of the worked and planned rosters and on speaking with residents, it was evident that the provider had sufficient staff with an appropriate skill mix to meet residents' needs. There were six registered nurses in the centre at night.

Judgment: Compliant

### Regulation 16: Training and staff development

While staff had access to a suite of training programmes to enable them to perform their respective roles, some gaps in adherence to mandatory training requirements required action, for example:

- 19 staff had not completed training in managing challenging behaviour.
- 21 staff had not completed IPC training.
- Three staff members had not completed training in safeguarding adults at risk of abuse.
- 24 nursing staff were overdue for a refresher in medication management training.

While staff compliance with the provider's fire safety training was 100%, further training was required to include procedures for vertical evacuation.

Judgment: Substantially compliant

### Regulation 19: Directory of residents

While the provider had a directory of residents, the directory did not contain all the information required under Schedule 3 of the regulations. For example, there were gaps in records relating to the residents' next of kin address and telephone number.

Judgment: Substantially compliant

## Regulation 23: Governance and management

While the provider had management systems to monitor the quality and safety of service provision, these oversight mechanisms required improvement to identify deficits and risks in service provision effectively and to continuously drive sustained quality improvement when risk was determined, for example:

- The provider's assurance systems had not been fully effective in addressing the known risks identified during this inspection in relation to healthcare, individual assessment and care planning, food and nutrition, fire precautions, training and staff development, premises, managing behaviour that is challenging, and residents' rights.
- The number of clinical incidents in the centre increased from 89 to 183 when the six-month periods of January to June 2024 and 2025 were compared. The largest incident category was residents' falls, totalling 110 in the January to June 2025 period. While the provider reviewed 10% of falls that resulted in an injury requiring medical attention, inspectors could not find evidence of a review of the other 90% of falls that occurred during the period. This lack of a review meant there had not been an exploration of the causal and contributory factors leading to these falls, to effectively identify deficits and risks in the service and increase resident safety.
- The secure storage of prescribed thickening agents was not fully effective, as the inspectors found that such products were accessible and not secured in six residents' bedrooms throughout the centre. These findings were brought to the attention of nurse management, who arranged for these products to be stored securely. These products are required to be used under supervision. Insecure storage of such thickening agents introduces a risk of asphyxiation by accidental ingestion of these products.
- The provider's systems required strengthening to ensure that residents' finances were managed in accordance with the provider's national financial regulations. For example, the inspector found that one staff member was receiving residents' funds from family members and issuing receipts for those funds, contrary to the provider's regulations, which require two staff members to be involved in the receiving and receipting processes. These deficits had also been identified by an independent auditor contracted by the provider in 2024.
- The oversight systems for ensuring that residents' records were securely and safely stored required review as inspectors found records relating to aspects of residents' daily care accessible within residents' bedrooms and located on grabrails outside residents' bedrooms.
- Inspectors observed some discrepancies between the floor plans and what they observed on the day of inspection. For example, the Grange visitor's room was operating as a staff office, the clinical treatment room outside Ferndale was operating as an ADON office and the linen store adjacent to the clean laundry was operating as a dried food store.

- The registered provider had not ensured that clear and effective procedures for vertical evacuation were in place, despite a competent person's recommendations being issued at the provider in 2022, findings from inspection reports of 11 January 2023 and 24 September 2024, and the provider's compliance plan commitments made after the September 2024 inspection. These matters are outlined under Regulation 28: Fire precautions.

Judgment: Not compliant

### Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of three residents' contracts and found that they set out the allocated bedroom number and occupancy. The contracts outlined the services to be provided and the fees to be charged, and referenced other services that residents may choose to avail themselves of at an additional cost, such as hairdressing.

Judgment: Compliant

### Regulation 4: Written policies and procedures

The policies required by Schedule 5 of the regulations were in place, updated in line with regulatory requirements and made available to staff in the centre.

Judgment: Compliant

## Quality and safety

The inspectors reviewed a sample of nursing notes and care plans. There was evidence that residents were comprehensively assessed upon admission to the centre using a suite of evidence-based risk assessment tools to evaluate risks, including falls, pressure sore development, malnutrition, manual handling needs, and dependency levels. Care plans were developed based on these assessment tools. The care plans viewed by the inspectors were person-centred and specific to each resident's needs. While acknowledging these good practices, some action was required to evidence consultation with the resident and, where appropriate, their family during the revision of care plans. This is discussed further under Regulation 5: Individual assessment and care planning.

The health of residents was promoted through ongoing medical review and access to a range of healthcare providers, including chiropodists, physiotherapists, speech and language therapists, and mental health services. Notwithstanding this good practice, the inspectors found that some action was required to ensure residents had access to additional professional expertise and a high standard of nursing care. This will be discussed under Regulation 6: Healthcare.

The provider had a training programme in place for staff to acquire up-to-date knowledge and skills appropriate to their role in responding to and managing challenging behaviour. Residents predisposed to episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had care plans and other documentation to guide staff. Records reviewed found that behaviour observation charts, such as the Antecedent, Behaviour and Consequence charts, were also being used to gain an understanding of the behaviour. The reviewed documentation was person-centred and described the behaviours, potential triggers for such behaviours, and de-escalation techniques to guide staff in delivering safe care. The inspector also observed that residents exhibiting responsive behaviours were supported compassionately and respectfully by staff. While acknowledging these good practices, further improvements were required in relation to the use of restraint, as discussed under Regulation 7: Managing challenging behaviour.

Staff were respectful and courteous towards residents. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by attending residents' meetings and completing questionnaires. The centre had religious services available. Residents had access to radio, television, newspapers and telephones. Some residents had internet service within the centre. Residents also had access to independent advocacy services. However, the inspector also found that some aspects of residents' rights were not upheld in the centre, and improvements were required by the provider as discussed under Regulation 9: Residents' rights.

The premises' design and layout met residents' needs. The centre was appropriately decorated to provide a homely atmosphere. There were secure outdoor areas, which were pleasantly landscaped. While acknowledging these positive aspects in relation to the premises, some areas required maintenance and repair to fully comply with Schedule 6 requirements, which will be discussed under Regulation 17: Premises.

Food was prepared and cooked onsite. Adequate quantities of food were observed to be provided during the day and in the evening. Residents had access to fresh drinking water and other refreshments throughout the day. Meals and snacks were provided at reasonable times. There was adequate supervision and discreet, respectful assistance at mealtimes. There was evidence of written communication between the nursing and catering teams to ensure that the dietary needs of each resident, as prescribed by healthcare or dietetic staff, were met. Notwithstanding these positive aspects, areas for improvement in relation to food in the centre will be discussed under Regulation 18: Food and nutrition.

The provider had systems in place to monitor fire safety. Preventive maintenance for fire detection, fire-fighting equipment, and emergency lighting was conducted at recommended intervals. Staff had undertaken fire safety training and participated in regular fire evacuation drills, practising progressive horizontal evacuation. There was a system for conducting checks of the fire alarm, means of escape, fire safety equipment, and fire doors. The inspectors found all means of escape kept clear. All bedroom doors were marked with a compartment identifier and the residents' evacuation support requirements. No residents who chose to smoke resided in the centre. Notwithstanding these good practices, additional actions were required to ensure the safety of residents in the event of a fire emergency. These findings are outlined under Regulation 28: Fire precautions.

The provider had ensured that a pharmacist acceptable to residents was made available. The records reviewed found that medicines were administered in accordance with the directions of the prescriber. Measures were in place for the handling and storage of controlled drugs in accordance with current guidelines and legislation. However, further oversight of medication storage and disposal was required to ensure that best-practice guidance and the provider's policies for medication management were followed. These findings are set out under Regulation 29: Medicines and pharmaceutical services.

### Regulation 11: Visits

The provider had a written visitor policy as required by the regulation. The inspectors observed that visits to the centre were encouraged. The visiting arrangements in place did not pose any unnecessary restrictions on residents. The registered provider had several private and communal spaces for residents to host a visitor.

Judgment: Compliant

### Regulation 12: Personal possessions

There were arrangements to support residents in accessing and retaining control over their personal property, possessions, and finances. Residents' clothes were laundered off-site by an external company. Residents had adequate space to store and maintain their clothing and possessions within their bedrooms, including access to locked storage facilities. Residents who spoke with the inspectors stated they were satisfied with the space in their bedrooms, storage facilities and laundry service.

The provider was a pension agent for seven residents and managed small quantities of funds for five further residents. The provider had a transparent system in which all lodgements and withdrawals of residents' personal funds were recorded in the provider's electronic record management system. The inspector saw evidence that the residents' funds were made available for their benefit as required.

Notwithstanding this good practice, the provider's systems required strengthening to ensure that residents' finances were managed in accordance with the provider's national financial regulations, as discussed under Regulation 23: Governance and management.

Judgment: Compliant

## Regulation 17: Premises

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas required maintenance, repair and review to be fully compliant with Schedule 6 requirements, for example:

- The exit door to a small secure garden on Grange was damaged, with the wooden frame of the door seen to be split.
- There was uneven and loose paving within the Grange internal courtyard and the courtyard accessible from the ground-floor café, posing a risk of falls and injury to residents.
- There were several loose overhead armature plates used to secure electromagnetic locks on doors, both on double doors to enter the units and on fire exit doors, presenting a risk to residents, visitors, and staff should they fall from their position.
- There were several double doors which had magnetic hold-open devices to allow the doors to remain open while a resident travelled through the doorway. However, inspectors noted that some of the armature plates designed to connect to a magnet to hold the door open were facing away from the magnet and not connecting, so the doors could not be held open. Inspectors observed this causing difficulties for residents seeking to travel through the double doors while using a mobility aid or a wheelchair.
- Action was also required to improve call-bell accessibility. On the second inspection day, inspectors found that two residents did not have access to their call bells, meaning they were unable to summon assistance if required. The call bells were found to be out of the resident's reach, for example, housed within the call bell holder or on a locker that was out of reach. Call bell access and response times had also been issues raised by residents at their committee meetings.
- Storage practices within the centre required review as inspectors found examples of inappropriate storage arrangements, including staff possessions stored in resident equipment storage areas, shower chairs and linen trollies stored in the sluice rooms and blocking access to the bedpan washer, and

boxes stored directly on the floor in multiple store rooms, impacting the ability to clean the floor.

- Inspectors found a damaged communal toilet door on Fernadale, with a sharp edge protruding from the door, which could injure a resident. This was brought to the immediate attention of the nurse manager in charge of that unit.

Judgment: Substantially compliant

### Regulation 18: Food and nutrition

The inspectors observed that the mealtime experience for residents required review to ensure that food and nutrition were delivered in line with the regulatory requirements, for example:

- Residents who required modified textured meals were not offered a choice of main course or tea-time meal, as confirmed by the catering staff on duty on both days of inspection and from the examination of the menu ordering sheets over the two inspection days.
- For residents who required modified diets, inspectors observed that modified consistency meals were not presented in a way that was attractive and appealing. Staff spoken with were unable to identify exactly what the meals consisted of.
- A small number of residents expressed dissatisfaction with the quality of food available, particularly at the tea-time meal. Other residents expressed their perception that there was limited variation in the meals and desserts provided. This feedback to inspectors aligns with feedback from residents' committee meetings and residents' questionnaires conducted during 2025.

Judgment: Substantially compliant

### Regulation 20: Information for residents

A guide for residents was available in the centre. This guide contained information for residents about the services and facilities provided, including complaint procedures, visiting arrangements, social activities and many other aspects of life in the centre.

Judgment: Compliant

### Regulation 26: Risk management

A risk management policy was in place, up to date, and contained the requirement as outlined in Regulation 26(1) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Similarly, there was a policy for responding to major incidents as outlined in Regulation 26(2).

Judgment: Compliant

### Regulation 27: Infection control

The provider had systems in place to oversee IPC practices within the centre. The centre's interior was very clean. Surveillance of healthcare-associated infections and multi-drug resistant organism colonisation was being undertaken and recorded. The volume of antibiotic use was also regularly monitored, and the provider sought to reduce prophylactic antibiotic use within the centre. The provider had appointed three trained infection control link nurses to provide specialist expertise, and staff had access to IPC training. A targeted auditing system was in place to regularly review staff practices and environmental cleanliness. The person in charge had completed a review following a recent influenza-A outbreak. Within the review, relevant protocols and guidance were documented as having been adhered to, and learning was identified in the event of a future outbreak.

A number of storage practices which posed a risk of cross-contamination required review and are discussed under Regulation 17: Premises.

Judgment: Compliant

### Regulation 28: Fire precautions

While acknowledging the provider's systems for monitoring fire precautions, the oversight of fire safety arrangements within the centre required review to ensure residents' safety.

The provider's evacuation plan consisted of three phases: phase 1: room evacuation, phase 2: horizontal compartment evacuation and phase 3: vertical evacuation. The building was on a sloping site, and access to ground level externally was available at both floors. The risk of requiring vertical evacuation was reduced by the building's configuration, which allowed horizontal escape from both floors. However, inspectors found that a robust review of arrangements for vertical evacuation from the first floor was required, as outlined below:

- The provider had contracted a competent person to review fire safety arrangements in the centre in 2022. This competent person's report was read

by inspectors, and it was noted that this person recommended clarity on the strategy for vertical evacuation. The centre was subsequently inspected by the Office of the Chief Inspector on 11 January 2023 and 04 September 2024. In both inspection reports, the need to incorporate vertical evacuation into the provider's fire safety procedures was referenced. The provider had made a compliance plan commitment following the 04 September 2024 inspection to incorporate vertical evacuation using the evacuation lift into the centre's evacuation strategy, to train staff to use the evacuation lift and to practice the use of the evacuation lift during fire drills by 31 December 2024. However on this inspection, inspectors found that the evacuation strategy had not been updated to include any details on vertical evacuation, that staff had not received training on using the lift during an evacuation, and that the strategy had not been practised during fire drills.

- While noting that there was no reference to vertical evacuation in the provider's current fire safety management policy provided to the inspectors by the person in charge, inspectors noted that there was conflicting information in respect of lift and stairs evacuation at nursing stations on the first floor, for example:
  - On Farronshoreen and Grange, the fire procedures located adjacent to the nursing station contained an action card number 7, which provided evacuation lift instructions for staff.
  - The displayed fire evacuation plan opposite the nursing station on Farronshoreen had five arrows, representing the directions of escape for staff to support resident evacuation. However, three of the arrows lead into stairwells which contained no evacuation aids for residents. This matter was brought to the attention of the person in charge, who commenced replacing the fire evacuation plan drawings during the inspection.

Arrangements for containment required review, for example:

- The door to the Farronshoreen nurse manager's office was seen to be propped open with a bin over the two inspection days.
- The arrangements for keeping the prayer room doors open for residents to enter and exit required review. A resident informed the inspectors that the ground-floor prayer room was usually kept open with a door stop; however, this would mean the doors would not close to contain fire and smoke in the event of a fire alarm activation.

Arrangements for displaying the procedures to be followed in the event of a fire required review, for example:

- Inspectors found that incorrect procedures, relating to non-residential areas, were displayed within the centre. This matter was brought to the attention of the person in charge, who commenced replacing the procedures during the inspection.

Precautions against the risk of fire require review, for example:

- Inspectors noted that all three units had an accessible activity room, containing a functioning cooker. The accessibility of these three cookers had not been risk-assessed by a competent person to determine the controls required to ensure the safety of residents using the activity room and surrounding areas.
- Assurances were required from the provider that the accessibility of these three cookers was in line with the provider's fire safety management policy and commitments made to the Chief Inspector in September 2024, both of which referenced that there would not be cooking outside of designated kitchens.
- The inspectors found that the ground-floor services void was being used to store cardboard refuse. A risk assessment must be completed by a competent person to determine the appropriate controls needed to manage the risk when using these areas for storage.

Judgment: Substantially compliant

### Regulation 29: Medicines and pharmaceutical services

The oversight of medication management in the centre required review to ensure that best-practice guidance for medication management was followed, for example:

- Inspectors found four boxes of expired nutritional supplements within an activity store room. The person in charge was required to ensure that medicinal products no longer required were returned to the pharmacy promptly, in accordance with the provider's medication management policy.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and care plan

While comprehensive person-centred care plans were developed, based on validated risk assessment tools, inspectors found that action was required to evidence consultation with the resident and, where appropriate, their family when care plans were reviewed.

Judgment: Substantially compliant

### Regulation 6: Health care

While residents had access to a range of healthcare professionals, improvements were required to ensure that all residents had timely access to appropriate professional expertise, based on their assessed needs, and to a high standard of evidence-based nursing care. For example:

- Inspectors reviewed the records of four residents who had experienced weight loss and were assessed to be at high risk of malnutrition. In accordance with the provider's nutrition policy, these residents should be reviewed by a dietitian. Records found that although these residents had been referred to a dietitian, the referrals had not been accepted, and as a consequence, the residents had not been reviewed by a dietitian regarding their weight loss. This lack of access to dietitian services is also contrary to the provider's statement of purpose and contract of care, which state that dietitian services are provided at no additional cost to the resident.
- Inspectors reviewed the records of three residents assessed to require oral care on a three-hourly basis. Records reviewed found no evidence of such care being provided in the last four, five and seven days, respectively.

Judgment: Not compliant

## Regulation 7: Managing behaviour that is challenging

Inspectors found examples where the centre's restraint usage was not in accordance with national policy published by the Department of Health or the provider policy, for example:

- While a risk assessment was completed before the usage of bedrails, this assessment was not always accurately completed; for example, alternatives trialled before bedrail usage were not always recorded.
- Inspectors also found that the risk balance tool, referenced within the provider's risk assessment tool, was not always completed as required. This was a repeat finding from the inspections of 04/09/2024 and 31/01/2024.
- The entry doors of each unit were locked and keypad-controlled, meaning residents could not access or leave their unit without staff support. The code for the keypad was not displayed for residents with decision-making capacity who wished to leave their unit independently to attend social activities in the ground café area or use the ground-floor prayer room.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

The inspectors found that action was required to ensure the rights of residents living in the centre were upheld at all times, as evidenced by the findings below.

Action was required by the registered provider to ensure that where residents raised issues at residents' committee meetings, these matters were actioned, for example:

- During the September 2024 inspection, it was noted that residents on Grange had repeatedly raised the issue of frosted privacy film on their bedroom windows, inhibiting their view of the surrounding scenery in residents' committee meetings. In the provider's compliance plan response, the provider committed to removing this privacy film and replacing it with an appropriate alternative by 31 December 2024. While inspectors found that some of the film had been reduced or removed to allow residents to see the views from their windows, six bedroom windows had not been addressed, and these residents continued to have their views inhibited.
- More recently, and throughout 2025, residents had expressed repeated concern regarding the loss of their accessible transport bus following an accident in January 2025. Inspectors reviewed minutes of meetings throughout 2025 in which residents enquired about the replacement of the bus; however, this had not been actioned by the inspection day.
- During 2025, residents had made several complaints about food quality and choice during the residents' committee meetings, particularly in the June 2025 meeting and via residents' questionnaires.

In terms of supporting residents to communicate freely, there continued to be no Wi-Fi coverage in the centre. This was first identified on inspection in June 2022. The provider had put interim arrangements in place while awaiting centre-wide Wi-Fi installation by providing internet dongles to residents who sought internet access. While residents acknowledged this effort, some pointed to difficulties accessing internet coverage in areas of the centre outside their bedrooms, where the dongle was located.

For all residents of the centre, the current organisation of the activities team did not ensure that all residents had an opportunity to participate in activities in accordance with their interests and capacities, for example:

- The provider had four WTE activity staff; however, on the first inspection day, one staff member was on duty. From reviewing the rosters, inspectors noted that there were occasions when three or four activity staff members were on duty together, and other occasions when only one activity staff member was on duty. While this staff member provided group activities in the ground-floor café area, no meaningful activities were observed for residents who remained in their units on the first inspection day. Instead, these residents were seen sitting for lengthy periods in the sitting rooms, with the television on but without other meaningful activity.
- A small number of residents informed the inspectors that there were not always activities available geared towards their interests and capacities, and that at times there were very few activities taking place.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
<b>Capacity and capability</b>	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 4: Written policies and procedures	Compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Waterford Residential Care Centre OSV-0007792

Inspection ID: MON-0048171

Date of inspection: 14/11/2025

## 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>Waterford Residential Care Centre has a comprehensive and structured training and staff development programme in place to ensure staff are appropriately skilled, competent, and supported to deliver safe, effective, and person-centred care in line with regulatory requirements.</p> <p>Mandatory training is provided across all key areas, including safeguarding adults at risk of abuse, infection prevention and control (IPC), medication management, fire safety, end-of-life care, and the management of behaviours that challenge. In response to the inspection findings, a detailed review of training compliance was undertaken and a targeted action plan implemented to address identified gaps.</p> <p>To strengthen governance and oversight of training compliance:</p> <ul style="list-style-type: none"> <li>• All Clinical Nurse Managers (CNMs) will receive quarterly training compliance reports for staff on their respective units. In Place as at 05/01/2026.</li> <li>• Training and education is a standing agenda item at monthly CNM and ward meetings, ensuring ongoing monitoring, escalation, and follow-up where required. In Place as at 05/01/2026.</li> </ul> <p>A training needs assessment was completed for all staff, and a comprehensive training and education programme for 2026 has been developed and implemented (completed 05.01.2026). This ensures all staff have access to required mandatory and role-specific training and that refresher training is scheduled within appropriate timeframes including:</p> <ul style="list-style-type: none"> <li>• Staff who had not completed training in managing behaviours that challenge have been identified, and training has been scheduled, with completion due by 23.02.2026.</li> <li>• Staff who required new or refresher IPC training have been identified, and training has been scheduled for completion by 02.03.2026.</li> <li>• Nursing staff who were overdue a medication management refresher have been identified, and refresher training has been scheduled for completion by 23.02.2026.</li> <li>• All staff have completed fire safety training, with compliance at 100%. In addition, vertical evacuation training has now been incorporated into all onsite fire training</li> </ul>	

sessions for 2026. The first session was completed on 14.01.2026, with ongoing sessions planned throughout the year.

IPC training and practice have been further strengthened through targeted initiatives and staff development:

- Two nurses have completed postgraduate education in Infection Prevention and Control, enhancing in-house expertise. In Place as at 05/01/2026.
- An IPC Link Practitioner has been allocated to each unit to support best practice, monitor compliance, and promote continuous improvement. In Place as at 05/01/2026.
- The Vi-Clarity audit system has been introduced to identify gaps in IPC practice and to support evidence-based quality improvement actions. In Place as at 05/01/2026.

Regulation 19: Directory of residents	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 19: Directory of residents:

- On admission, all residents will have all required information as outlined in Schedule 3 recorded in the Directory of Residents, including the name, address, and telephone number of the resident’s next of kin or nominated representative. In Place as at 05/01/2026.
- Where any required information is unavailable at the time of admission, this will be clearly identified and followed up by the Clinical Nurse Manager (CNM) on the relevant unit. Once obtained, the directory will be updated without delay. In Place as at 05/01/2026.
- The Centre’s Management Team will monitor and maintain the Directory of Residents on a weekly basis to ensure it is complete, accurate, and up to date. In place 05/01/2026.

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 management team conducts regular reviews of staffing levels, clinical care delivery, incident data, audit outcomes, and operational requirements. Any identified risks or deficits are escalated through the governance structure to the PIC, PPIM, and senior

management, with clear accountability for action and follow-up. These governance arrangements also support continuous quality improvement initiatives, including service development, environmental improvements, and access to appropriate therapeutic and recreational resources for residents. (01.01.2026)

#### Incident Management and Falls Governance

- In response to the significant increase in clinical incidents, particularly residents' falls between January–June 2025, the management team, in collaboration with HSE Risk Management, commenced a comprehensive falls audit, clinical review, and staff workshop programme on 02.12.2025.
- Going forward, all falls incidents will continue to be reviewed to identify causal and contributory factors, trends, and learning outcomes, in line with the National Incident Management Framework.
- Quarterly falls analysis reports will be completed in 2026 for each unit, with findings, actions, and learning outcomes discussed at CNM meetings and communicated to staff at unit level to reduce risk and improve resident safety.

#### Risk Management and Assurance Systems

- Risk management systems are in place to identify, assess, manage, and monitor risks, supported by audits, incident trend analysis, and management oversight (01.01.2026).
- Findings from audits and incidents inform service improvement plans, which are monitored for completion and effectiveness through the centre's governance framework.

#### Medication Safety and Thickening Agents

- The storage of all medicinal products, including prescribed thickening agents, is managed in line with the HSE Medication Management Policy. All thickening agents are securely stored and accessible only under staff supervision (05.01.2026)
- Quarterly medication management audits, including storage practices, have been introduced, with the first audit completed in January 2026 and ongoing thereafter.

#### Management of Residents' Finances

- A revised Policy for the Management of Residents' Personal Property, Personal Finances and Possessions was implemented in January 2026.
- Clear staff roles and responsibilities were assigned on 16.01.2026, ensuring that two staff members are present at all times when receiving residents' funds and issuing receipts, in line with National Financial Regulation NFR C1.
- Compliance with this policy is monitored through routine audits and management oversight.

#### Records Management and Confidentiality

- Residents' daily care records previously accessible in bedrooms have been transferred to secure folders and stored in locked cabinets within designated clinical record areas.
- Access is restricted to authorised staff only, ensuring residents' information is secure, confidential, and readily available to support safe care delivery.

#### Premises Oversight and Use of Space

- A full review of room usage has been completed to ensure that actual room function aligns with approved floor plans.
- Floor plans have been updated to accurately reflect current room usage and will be submitted to the regulatory body by 23.01.2026. Staff have been informed of correct room designations to ensure ongoing compliance.
- The Fire Safety Officer reviewed room usage against floor plans. The clinical treatment room is now secured, a separate ADON office has been established, and the Grange visitor's room has been restored to its intended purpose.

Fire Safety and Vertical Evacuation

- In-house vertical evacuation fire training for staff has commenced and will continue throughout 2026 to ensure staff competence and preparedness. Clear procedures are being implemented to ensure safe and effective evacuation in the event of a fire – for implementation by 30.06.2026.
- Fire safety arrangements are monitored through audits, drills, and management review to ensure sustained compliance with Regulation 28: Fire Precautions.

Regulation 17: Premises

Substantially Compliant

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

- A full review and assessment of the exit door to the small secure garden on Grange was completed by Technical Services on 16.12.2025 and it now operating safely.
- The paving within the Grange internal courtyard and the courtyard accessible from the ground-floor café will be reviewed by Technical Services and appropriate safety interventions to be completed by 01/05/2026.
- All overhead armature plates securing electromagnetic locks on unit entry doors and fire exit doors are being inspected, tightened, or replaced as required to ensure they are secure and do not pose a risk to residents, visitors, or staff (for completion 28.02.2026)
- All double doors fitted with magnetic hold-open devices are being inspected to ensure armature plates are correctly aligned with magnets so that doors function as intended and support safe mobility for residents using aids or wheelchairs. Staff have been instructed to immediately report any door malfunction to Technical Services (for completion 28.02.2026)
- The damaged communal toilet door on Ferndale was repaired on 17.11.2025.
- Systems have been reinforced to ensure call bells are accessible to all residents at all times. Staff are required to place call bells within residents' reach following care delivery. Where residents require additional supports to access call bells, occupational therapy referrals are made and appropriate interventions implemented. Call bell accessibility will be monitored by CNMs on each unit, with compliance audited as part of the environmental audit scheduled for March 2026.

- Call bell response times are addressed during ward handovers and ward meetings and are a standing agenda item for discussion. CNMs complete daily walk-around checks to ensure compliance (in place 19.01.2026).
- Storage practices across the centre have been reviewed in full, and all inappropriate storage arrangements were rectified with immediate effect.
- Equipment storage areas, sluice rooms, and store rooms are now maintained in a manner that allows safe access, effective cleaning, and infection prevention.
- Ongoing monitoring is supported through daily CNM walk-arounds and an environmental safety walkabout audit scheduled for March 2026.

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

- A Quality Improvement Plan (QIP) focused on enhancing the mealtime experience and delivery of food and nutrition has been developed and will commence in February 2026.
- A new daily meal order form has been developed to ensure that all residents, including those requiring modified textured diets, are offered and supported to make a choice of main meal and tea-time meal each day. This process will commence on 03.02.2026.
- Ward menus will be updated to clearly reflect choice and variation, including options for modified textured diets, ensuring residents receive meals aligned with their assessed needs and preferences.
- The presentation of modified consistency meals will be reviewed and improved to ensure meals are appetising, recognisable, and dignified, in line with best practice.
- Catering and care staff will be supported to ensure they have a clear understanding of meal composition and texture requirements, enabling them to appropriately describe meals to residents and support informed choice.
- Residents will be actively engaged throughout the improvement process, including through resident forums, residents' committee meetings, and direct feedback at ward level. Feedback from resident questionnaires and forums will be used to guide menu changes and service improvements.
- A review of resident feedback and outcomes from the QIP will be completed by June 2026, with further actions implemented as required to ensure sustained improvement

Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ul style="list-style-type: none"> <li>• Vertical evacuation training has been formally incorporated into the annual onsite fire safety training programme for all staff, which commenced on 14.01.2026.</li> <li>• Fire drills will now routinely include vertical evacuation scenarios, including the use of the evacuation lift, to ensure staff competence and confidence in evacuating residents safely from the first floor when required.</li> <li>• The Fire Safety Management Policy is being updated to explicitly include vertical evacuation procedures, including the use of the evacuation lift (to be completed by 02.02.2026).</li> <li>• A full review of fire evacuation plans, drawings, and action cards across the centre has been undertaken. Incorrect procedures relating to non-residential areas have been removed, and updated evacuation plans reflecting correct escape routes and evacuation aids are being displayed.</li> <li>• Action Card Number 7, which provides staff instructions for evacuation using the lift on Farronshoreen and Grange, will be formally incorporated into the policy. This update will remove conflicting information regarding evacuation via lifts or stairs and provide staff with clear, consistent guidance aligned with training and practice. For completion 02.02.2026.</li> <li>• A review of fire containment arrangements has been completed.</li> <li>• Staff have been formally reminded of the risks associated with propping fire doors open, including during handovers and safety pauses.</li> <li>• Spot checks are carried out by CNMs, and daily fire wardens on each unit include door checks as part of their responsibilities (implemented 12.01.2026 and ongoing).</li> <li>• Arrangements for communal areas, including the prayer room, have been reviewed to ensure doors are not held open in a manner that compromises fire and smoke containment.</li> </ul> <p>Cooking Facilities in Activity Rooms</p> <ul style="list-style-type: none"> <li>• Each residential unit has an accessible activities room equipped with a cooker for resident engagement and activities.</li> <li>• These cooking areas have been formally designated as approved activity kitchens and are permitted for use in line with the service's Fire Safety Management Policy.</li> <li>• A fire risk assessment for these cookers was completed by a competent person on 01.12.2025, confirming appropriate control measures.</li> <li>• A Standard Operating Procedure (SOP) for each cooker has been developed and is displayed adjacent to each unit.</li> <li>• Appropriate fire safety and emergency equipment is available within safe proximity of each cooker.</li> <li>• Pre- and post-use safety checklists have been implemented to ensure safe operation during resident activities. (Completed 01.12.2025).</li> </ul>	

## Storage

- All equipment and waste materials, including cardboard refuse, are now stored only in designated, appropriate storage areas, in line with fire safety requirements (implemented 15.11.2025).
- The ground-floor services void is no longer used for storage.
- Storage practices are monitored through environmental audits and fire safety walkabouts.

Fire safety arrangements are monitored through routine audits, drills, staff training, and management oversight.

Regulation 29: Medicines and pharmaceutical services

Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- HSE-Land Medication Management Training will be completed by all nursing staff by 31.03.2026, ensuring staff knowledge and competence in safe medication practices, including storage, stock control, and disposal of medicinal products.
- Quarterly medication management audits have commenced across all units within Waterford Residential Care Centre. These audits include review of medication storage areas, expiry date checks, stock control, and compliance with the medication management policy. The next audit is scheduled for January 2026, with findings reviewed and actions monitored by the PIC and PPIM.
- Clinical Nurse Managers (CNMs) on each unit are responsible for ensuring weekly medication stock control checks, including monitoring of expiry dates, appropriate storage conditions, and stock quantities. In place 05.01.2026
- All expired or discontinued medicinal products, including nutritional supplements, are now returned promptly to the pharmacy, in line with the procedures outlined in the service's medication management policy. In place 05.01.2026

Regulation 5: Individual assessment and care plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <ul style="list-style-type: none"> <li>• Residents continue to have individualised care plans developed following comprehensive assessment using validated assessment and risk assessment tools. Care plans are reviewed regularly and updated to reflect changes in residents' health status, personal preferences, and social needs.</li> <li>• Consultation with residents is now explicitly required at admission and at each care plan review. Where appropriate, family members or nominated representatives are engaged to support decision-making and person-centred planning.</li> <li>• All resident and family consultation is clearly documented within the care plan, including the date of consultation, participants involved, and the resident's views, preferences, and agreed outcomes.</li> <li>• Monthly care plan audits, completed as part of the nursing metrics framework, now include a specific check to confirm evidence of resident and family consultation. Any gaps identified through audit are actioned promptly, with follow-up to ensure documentation is complete and reflective of meaningful engagement. In place 05/01/2026.</li> </ul> <p>RANP in Dementia Service</p> <p>The RANP in Dementia service has been reviewed and below changes are commencing from the 05.01.2026:</p> <ul style="list-style-type: none"> <li>• The RANP Dementia residential service aims to improve the transition experience of residents coming to live at WRCC through structured engagement with the resident and their loved ones. The resident will have a full geriatric assessment on admission, be reviewed at 6 weeks and again at 6 months.</li> <li>• A family information session will be had with family members, the role to the RANP Dementia to answer any questions re dementia and topics directly affecting the resident while providing emotional support to families as their loved one transitions to residential care.</li> <li>• The RANP Dementia can also be referred to in the event of new onset non cognitive symptoms to complete a full assessment or review a previous assessment prior to referral to POLL.</li> </ul>	
Regulation 6: Health care	Not Compliant

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

- A professional dietetic service has been commissioned to provide weekly on-site dietetic support to Waterford Residential Care Centre. The service is scheduled to commence in February 2026, ensuring residents assessed as being at risk of malnutrition receive timely specialist review.
- Pending dietitian review, residents identified as high risk of malnutrition are reviewed by nursing staff and their GP, and immediate nutritional interventions are implemented, including nutritional supplements, fortified diets, food and fluid intake monitoring, and weight surveillance.
- Any deterioration in nutritional status is promptly escalated to the GP for further clinical review, ensuring continuity of care in line with the centre's nutrition policy, statement of purpose, and contract of care.
- • Daily monitoring of oral care provision is carried out by CNMs as part of routine checks. Compliance with oral care plans is included in relevant audit processes, with any gaps identified addressed promptly (implemented 01.01.2026). Residents assessed as requiring regular oral care interventions, including three-hourly oral care, now have this care clearly documented within their care plans and recorded at each episode of care delivery.

Regulation 7: Managing behaviour that is challenging

Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

#### Staff Training and Competence

- In-house Positive Behaviour Support training has been implemented for 2026 and commenced on 13.01.2026, ensuring staff are competent in recognising, preventing, and responding to behaviours that challenge in a person-centred, least-restrictive manner.
- Ongoing education on restrictive practices is delivered in-house by a nurse completing a research Master's in restrictive practice, supporting evidence-based care.

#### Bedrails and Restrictive Practice Assessments

- All bedrail risk assessments are being reviewed and updated to ensure they are completed accurately and in full.
- Staff are required to clearly document all alternatives trialled prior to the use of bedrails

and to fully complete the risk balance tool, as referenced within the provider's assessment documentation.

- Clinical Nurse Managers (CNMs) monitor compliance at ward level, provide guidance and supervision to staff, and ensure that assessments are accurate and person-centred.

#### Unit Entry Doors

- Unit entry doors remain keypad-controlled for safety further to risk assessment; however, arrangements have been reviewed to ensure residents' rights, autonomy, and freedom of movement are respected.
- Residents with decision-making capacity who are assessed as safe to leave the unit independently are now provided with the keypad code on an individual basis.
- Each resident's ability to remember and safely use the code is assessed and documented. Where a resident cannot reliably use a keypad code, alternative access methods (such as a personal keycard or fob) are provided.
- Residents are encouraged to inform staff when leaving the unit to support fire safety and oversight, while maintaining autonomy and choice.
- These measures ensure a proportionate balance between safety and residents' rights, in line with Regulation 7 and Regulation 9.

The service continues to implement its Restrictive Practices and Residents' Rights Quality Improvement Plan, with the aim of reducing restrictive practices across the centre.

- The Person in Charge (PIC) conducts weekly reviews of the restrictive practice log to identify opportunities to reduce or eliminate restraint where safe to do so.
  - A standardised, person-centred approach to care planning is maintained across all units, with regular reviews in line with regulatory requirements.
  - Six-monthly audits of restrictive practices and associated care plans are completed on each ward, with actions monitored and closed out through governance structures.
  - Quarterly meetings of the WRCC Restrictive Practice Committee are held to review data, trends, and improvement actions.
  - Policies relating to restrictive practices are regularly reviewed and updated, with staff supported to remain informed and compliant with national policy.
  - Equipment procurement and ward resources are reviewed regularly to support alternatives to restraint.
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- Reducing restrictive practices is a standing agenda item at CNM and ward meetings, with actions documented and followed up.

Regulation 9: Residents' rights

Not Compliant

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

- Residents' rights and diversity continue to be promoted and protected throughout the centre. Staff are aware of the importance of respecting cultural, religious, and personal preferences, and practice is regularly monitored through audits, observations, and supervision.
- Action plans from residents' committee meetings now include the responsible person, clear timelines, and sign-off once completed to residents' satisfaction.
- Assistant Director of Nursing (PIC) or Director of Nursing (PPIM) attend resident forum meetings, with items escalated to the Manager of Older Persons Services as required.
- Issues raised are incorporated into monthly CNM and ward meeting agendas, ensuring accountability and timely follow-up.

#### Privacy Film on Windows – Grange Ward

- A plan is in place to remove and replace remaining six bedroom window films to restore residents' views, with completion by 27.02.2026.

#### Accessible Transport Bus

- A business case for a replacement bus has been submitted to the IHA Manager for the 2026 budget.
- Interim arrangements include the provision of a temporary vehicle – which will be in place by 30.01.2026.
- Seasonal outings were facilitated using private hire during the Christmas period to maintain resident access to activities.

#### Food Quality and Choice

- Menus and food provision processes are under review to ensure meals meet residents' preferences, nutritional needs, and cultural requirements. A Quality Improvement Programme in the provision of meals and choices will commence on 02/02/2026.
- Feedback from residents via committee meetings, questionnaires, and direct engagement informs improvements. Outcomes and menu changes are communicated back to residents to ensure transparency and ongoing improvement.

#### Wi-Fi Access

- The service has identified a significant increase in residents' need for internet access. Interim measures have been implemented, including deployment of five WiFi dongles across the home, prioritising areas with the greatest need. This provides improved access while a long term centre-wide WiFi solution is being progressed through HSE Capital & Estates. Feedback from residents will continue to guide further improvements, ensuring equitable access and ongoing support for autonomy, choice and digital engagement.
- The centre will continue to advocate for prioritization of WiFi installation as soon as possible.

#### Activities and Meaningful Engagement

- A full review of resident activities has been completed in collaboration with the WRCC management team, with input from resident satisfaction surveys and focus on individual

activities at ward level.

- Activities staffing has been reconfigured to ensure dedicated staff for each unit, allowing balanced programming across seven days each week. This ensures residents in all units have access to meaningful individual and group activities. In place 12.01.2026.
- CNMs and the activities team now generate unit-specific activities programs reflecting residents' individual interests, capacities, and care plan documentation. In place 12.01.2026.
- Larger group activities such as chair yoga, music sessions, Mass, and bingo continue in the main coffee dock area but are coordinated jointly by CNMs and the activities team. In place 12.01.2026
- Activities documentation has been reviewed and improved at unit level to record participation, interests, and outcomes (completed 12.01.2026). Enhancements to meaningful activities are now a standing agenda item at CNM, ward, and resident meetings. Individual resident needs and preferences are documented in care plans to ensure access to appropriate recreational and stimulating activities - completed 31.12.2025.

## 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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/03/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/02/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	01/01/2026
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Substantially Compliant	Yellow	01/01/2026

	are wholesome and nutritious.			
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	01/01/2026
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	01/01/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/01/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the	Substantially Compliant	Yellow	30/03/2026

	procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	01/01/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/01/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	30/03/2026
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in	Substantially Compliant	Yellow	30/03/2026

	the designated centre.			
Regulation 29(2)	The person in charge shall facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.	Substantially Compliant	Yellow	01/01/2026
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	01/01/2026
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the	Substantially Compliant	Yellow	01/01/2026

	product concerned can no longer be used as a medicinal product.			
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	01/01/2026
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 from time to time, for a resident.	Substantially Compliant	Yellow	28/02/2026
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	Not Compliant	Orange	28/02/2026

	paragraph (1) or other health care service requires additional professional expertise, access to such treatment.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/01/2026
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident is facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media.	Substantially Compliant	Yellow	01/01/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	12/01/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with	Substantially Compliant	Yellow	12/01/2026

	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	01/01/2026