Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St. Camillus Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Shelbourne Road, Limerick
Type of inspection:	Unannounced
Date of inspection:	10 March 2025
Centre ID:	OSV-0008706
Fieldwork ID:	MON-0043975

About the designated centre

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 10 March 2025	09:00hrs to 17:00hrs	Sean Ryan	Lead
Monday 10 March 2025	09:00hrs to 17:00hrs	Ruta Graham	Support

What residents told us and what inspectors observed

Residents living in St. Camillus Community Nursing Unit were complimentary of the quality of care they received from staff who they described as caring, patient, and kind. Residents told the inspectors that the management and staff valued their feedback and generally made them feel included in the decision about how the service is run, and how the quality of the service could be improved. Residents told the inspectors that staff were attentive to their needs and made them feel safe living in the centre.

Inspectors were met by the person in charge and an assistant director of nursing on arrival at the centre. Following an introductory meeting, the inspectors walked through the centre, reviewed the care environment and met with the majority of residents and spoke to eight residents in detail about their experience of living in the centre.

There was a calm and relaxed atmosphere in the centre throughout the inspection. During the morning, staff were observed to respond to residents requests for assistance promptly. Staff appeared to pace their work so that they had time to engage socially with residents when providing care. Residents told inspectors that they never felt rushed by staff and they reported that they were always greeted with respect. Residents told the inspectors that they knew some of the staff very well, but also added that there were a lot of staff that were new and that they did not know. Residents reported that this could sometimes result in their care not being delivered according to their preferences.

St. Camillus Community Nursing Unit is a new purpose-built designated centre for older persons. The centre was registered to accommodate 50 residents with a range of dependency and needs. Bedroom accommodation comprised of 46 single and four twin-rooms laid out over two floors. All rooms had accessible en-suite facilities.

The premises was well- maintained, appropriately decorated, clean, well-lit, and warm for residents. Corridors were wide and spacious, containing appropriately placed hand rails to support residents to walk independently around the centre. There was a large enclosed garden accessible to residents. There was ample storage facilities for equipment, and corridors were maintained clear of items that could obstruct residents who were observed walking around the centre throughout the day. Furnishings in communal areas and bedrooms were observed to be well-maintained and comfortable for residents.

The inspectors saw that fire safety was appropriately managed in the centre. Fire doors were observed to be clear of obstructions and doors were closed to support containment of fire in the event of an emergency. Information pertaining to evacuation procedures was conveniently located at the nurses' station to ensure easy access during an emergency.

Residents bedrooms were personalised with items such as family photographs, colour- coordinated soft furnishings, and ornaments. In general, residents were satisfied with their bedrooms and comfortable furnishings. Residents told inspectors that they were encouraged to personalise their bedrooms to create a homely feel and appearance. Residents were satisfied with storage facilities within their bedroom and the option to securely store their valuables in a lockable storage cabinet.

Residents informed the inspectors that they had daily access to a shop in the centre where they could purchase newspapers, drinks, confectionery and a variety of other items. Residents described how staff provided them with their requested items but they were unclear about the payment process for the items obtained from the shop. A resident described how staff assisted them to manage their finances and accounts. However, a resident recounted that, while they had asked staff for the balance of their account to ensure they had enough money to make purchases from the shop, they had not been provided with this information. One resident compared their experience of accessing their finances in a bank to the nursing home's system, stating that accessing their finances was easier through a bank than through the nursing home financial management system.

The inspector observed that the lunch time dining experience was an unhurried, social occasion. Residents could choose to have their lunch in the dining room, in one of the sitting room areas or in their own bedroom. A resident told the inspector that 'the food is excellent here', and another resident said that 'there is always a good choice of food'. Staff providing assistance to residents with their meals did so in a manner that ensured the resident's dignity was respected.

Inspectors observed that residents were socially engaged during the inspection. Residents attended group activities in the main communal areas on each floor. Staff were present to provide meaningful social engagement and assist residents with snacks and refreshments.

The majority of residents spent their day in the communal dayrooms on each floor. The inspectors spent time here, observing the interactions between the staff and residents. Staff were attentive to the needs of the residents. Inspectors observed a number of staff and resident interactions during the inspection. In general, residents were seen to be relaxed and comfortable in the company of staff. Staff were observed assisting residents with their care needs and overall, staff provided this support in a patient and respectful manner. However, inspectors observed an incident where the manner in which staff assisted a resident with complex care needs was not in line with best practice guidelines of the residents care plan.

Residents could receive visitors within communal areas or in the privacy of their bedrooms. Multiple families and friends were observed visiting residents during the inspection day.

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

Capacity and capability

This was an unannounced inspection carried out over one day by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

The findings of this inspection were that the provider had taken action to address issues identified on the last inspection in August 2024 to ensure the premises was appropriately maintained and that the physical environment and evacuation procedures protected residents from the risk of fire. However, this inspection found that there was ineffective governance of the management of residents' finances, which failed to ensure that residents were adequately supported to retain control over their personal property and finances. Furthermore, inspectors found that the systems in place to ensure effective monitoring and documentation of resident's finances were not effective. As a consequence of these concerns, an urgent compliance plan request was issued to the provider following this inspection.

The Health Service Executive is the registered provider of St. Camillus Community Nursing Unit. The organisational management structure for the designated centre consisted of the head of social care and the general manager of older person services who provided operational oversight and support to the person in charge. This centre was first registered in June 2024. As part of the registration, the Chief Inspector attached an additional condition to the registration of the centre. Condition 4 required the registered provider to nominate a person who would participate in the management of centre by 31 October 2024. The purpose of the restrictive condition was to ensure that person in charge was adequately supported by a suitable management team and to ensure that there was a sufficient and clearly defined management structure in the designated centre. The findings of this inspection were that the provider had failed to comply with the requirements of a condition of registration.

The person in charge of St. Camillus Community Nursing Unit was also responsible for the management of another designated centre for older persons located on the campus grounds. The person in charge was supported by an assistant director of nursing in the administration of the service and clinical nurse managers. However on the day of the inspection, the clinical nurse management support for the person in charge was not in place as described in the centre's statement of purpose, which detailed a management structure to include four clinical nurse managers (CNM). Two clinical nurse manager positions were vacant. This organisational structure was found to impact on the supervision and monitoring of some aspects of the service such as the oversight of residents' clinical care records and the systems in place to evaluate and improve the quality and safety of the service.

Inspectors found that accountability and responsibility for the oversight of some aspects of the service was unclear, particularly in relation to resident records and their finances. For example, responsibility for the management of residents' finances

had been devolved to administration personnel outside of the designated centre. Consequently, residents could not access their funds outside of administration staff working hours. In addition, this meant that the person in charge of the designated centre did not have direct access to, or sight of documents relating to charges to residents, and monies held on behalf of residents. This also impacted on residents awareness of, and access to, all monies held for them by the registered provider and records regarding their accounts.

The person in charge had identified that inadequate access to monies and records of financial transactions was an issue impacting on the rights of a number of residents in the centre. The risk had been assessed by the person in charge and escalated to the provider for further review and action. However, the provider had not reviewed the risk to residents or established the number of residents affected. Consequently, there was no plan in place to appropriately manage the risk and residents continued to be impacted.

A review of the record management systems in the centre found issues of non-compliance with the requirements of the regulations. While records pertaining to staff personnel files were appropriately maintained, records pertaining to monies deposited by residents, to be held by the provider, were disjointed and not appropriately maintained. In addition, documents requested for review at the start of this inspection were not received in a timely manner. Requests for information with regard to the management systems in place such as risk management, complaints, audits, and assessments were presented in a disjointed and disorganised manner. Some documents in relation to incidents and fire safety were not provided on the day of the inspection. Furthermore, some records relating to residents finances were not kept in the designated centre, as required under Schedule 3 of the regulations.

A review of the centre's staffing roster 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 house-keeping, catering and maintenance staff in place.

There was a training and development programme in place for all grades of staff. Records showed that most staff were facilitated to attend training in fire safety, safeguarding of vulnerable people, and supporting residents living with dementia. However, a significant number of staff had not completed training in supporting residents to manage their responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors observed that the needs of some residents with complex care issues and behaviours were not being appropriately met.

Regulation 15: Staffing

On the day of the inspection, the staffing level and skill mix were appropriate to meet the needs of residents, in line with the centre's statement of purpose.

There was sufficient nursing staff on duty at all times, and they were supported by a team of health care staff. The staffing compliment also included catering, housekeeping, administrative and management staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately trained to deliver effective and safe care to residents. For example;

- A review of training records found that a significant number of staff had not been facilitated to attend training relevant to supporting residents to manage their responsive behaviours. Inspectors observed that some staff had not received up-to-date knowledge and skills, appropriate to their role, to respond to and manage behaviours that were challenging. This posed a risk to the quality of the care provided to some residents.

In addition, a significant number of staff had did not have up-to-date training in fire safety, safeguarding of vulnerable people, and manual handling.

Judgment: Substantially compliant

Regulation 21: Records

Following this inspection, the provider was required to submit an urgent compliance plan to address the failure to maintain all records pertaining to resident finances in the designated centre in accordance with 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. In addition, records of any money or valuables returned to residents, including finances of deceased residents, were not appropriately maintained. The providers response did not provide assurance that the risk was adequately addressed.

In addition, records were not maintained in a manner that was accessible. For example;

- Records required under Schedule 4 were not made available for inspection. This included records of testing and maintenance of fire equipment and emergency lighting systems.

- A full and complete record of all incidents involving residents was not made available for inspection, in line with the requirements of Schedule 3 of the regulations.

Judgment: Not compliant

Regulation 23: Governance and management

The organisational structure, as described in the centre's statement of purpose, was not in place. On the day of the inspection, vacant positions in the clinical nurse management structure had resulted in a reduced level of supervisory staff available to be rostered. This was found to impact on the effectiveness of nursing oversight, accountability and responsibility for some aspects of the service such as the quality of clinical care records and the oversight of the care provided to residents.

The registered provider had not ensured that there was an effective management structure in place. Unclear roles and responsibilities impacted on accountability and responsibility for the oversight and management of key areas of the service such as the management of records, residents' finances, and the systems in place to monitor and improve the quality of the service. This impacted on the effectiveness of the action taken to address risks and regulatory non-compliance identified in those areas.

In addition, the provider had failed to comply with a condition of registration. The provider had failed to nominate a person who would participate in the management of centre by 31 October 2024.

The management systems in place did not ensure that the service provided was safe, consistent and effectively monitored. This was evidenced by;

- Poor oversight of record management systems to ensure compliance with the regulations. This meant that accurate and up-to-date information, relating to money held by the provider on behalf of residents, including current, discharged and deceased residents, was not available in the designated centre.
- The systems in place to manage and access records was not robust. For example, in the absence of nominated staff members, access to some key records was not possible, and the systems to monitor records to ensure full compliance with the regulations was poor. There was no clear policy, procedure and robust system to underpin an effective record management system.
- Risk management systems were not effectively implemented to manage risks in the centre. Risks that had been escalated by the local management team to the provider were not managed in line with the centre’s own risk management policy. For example, inadequate access to records pertaining to residents finances was an issue impacting on residents. While this risk had

been escalated to the provider, there was no effective plan in place to address or manage the risk.

- Some of the systems used to evaluate and improve aspects of the service were not effective. For example, audits of residents records and care plans carried out in January 2025 had identified that quality improvement actions were required. However, the action plans developed had not been completed within the required time frame, and there was no system in place to ensure the status of improvement action plans were reviewed and completed. This resulted in ineffective action being taken to address the deficits identified.

Judgment: Not compliant

Quality and safety

Residents living in St. Camillus Community Nursing Unit received a satisfactory standard of care which ensured that they were safe. Residents were satisfied with their access to health care, and reported feeling safe and content living in the centre. However, this inspection found that residents' care plans did not always reflected the care provided to residents and were not always reviewed or updated to reflect their changing care needs. In addition, inspectors found that aspects of the quality and safety of care provided to residents was impacted by inadequate governance and management as described under the Capacity and Capability section of this report. In particular, urgent compliance was required to ensure residents were provided with access, information, and support pertaining to their personal finances and to ensure that their rights were upheld.

Residents were provided with facilities to safely store their personal possessions that included mementos, souvenirs and photographs. Bedrooms were equipped with lockable storage to securely store residents valuables and monies, if they wished. The provider supported a number of residents to manage their financial affairs such as pension payments. However, inspectors found that residents were not appropriately supported to maintain control over their finances. For example, residents were not routinely provided with information about monies held by the provider on their behalf. In addition, residents could not freely access their finances if required or requested.

All residents had a care plan, and there was evidence that residents needs had been assessed using validated assessment tools. However, the care plans reviewed were not always informed by these assessments, and did not reflect person-centred guidance on the current care needs of the residents. For example, a resident assessed as being at high risk of dehydration did not have an appropriate care plan developed to provide guidance on managing the risk. In addition, residents who had experienced weight-loss did not have an appropriate assessment of their nutritional

risk completed. Consequently, care plans were not reflective of the residents nutritional risk and care needs.

A review of residents' records found that there was regular communication with residents' general practitioner (GP) regarding their health care needs and residents were provided with access to their GP, as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further expert assessment and treatment. This included access to the services of speech and language therapy, dietetics, occupational therapy, physiotherapy, and tissue viability nursing expertise.

Activities were observed to be provided by dedicated activities staff, with the support of health care staff. Residents told the inspector that they were satisfied with the activities on offer. There were opportunities for the residents to meet with the management team and provide feedback on the quality of the service.

Residents had access to local and national newspapers, radios, television, telephones and internet services. There were arrangements in place for residents to access independent advocacy services. Residents had access to television, radio, newspapers and books.

However, the civil rights of residents were not consistently upheld. Residents who were dependent on the registered provider for support and assistance to manage their finances lacked unrestricted access to their funds outside of standard working hours of staff and information about their accounts. This was compounded by staff not being informed of the correct procedure for residents to access their accounts, leading to inconsistent guidance and responses from staff. As a result, some residents were worried whether they had sufficient funds to cover day-to-day expenses or the cost of their care. While one resident stated that they had requested information about their finances from staff, the response from staff in relation to their request did not alleviate their concerns.

Regulation 12: Personal possessions

The registered provider failed to ensure that there were adequate measures in place to support some residents in manage their financial affairs. Residents for whom the provider was a pension agent for did not have appropriate access to their personal finances, and there was poor evidence that there was sufficient supports in place to enable residents to retain control over their finances.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not always informed by assessment of the residents care needs. For example, two residents who had experienced significant weight loss were not did not have an assessment of their risk of malnutrition completed. Consequently, care plans did not contain accurate information to guide the care to be provided to the residents.
- Care plans were not always updated when a resident's condition changed. For example, a care plan had not been updated to reflect changes in a resident's nutrition and hydration and the increase in support and intervention necessary by staff to support this aspect of their care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre as required or requested.

Services such as physiotherapy, tissue viability nursing expertise, speech and language and dietetics were available through a system of referral.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' civil rights were not upheld, as they were not supported to access or manage their personal finances in a timely manner. The provider's response to an urgent compliance plan did not provide assurance that this risk was adequately addressed.

Individual account ledgers were not maintained in the centre, and statements of residents' accounts were issued infrequently. This limited residents ability to monitor their own accounts and financial transactions.

This was compounded by a lack of clear arrangements in place to facilitate residents' to access their financial information or accounts outside of normal staff working hours. This impacted on residents to autonomy, choice, and supporting residents' financial independence.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St. Camillus Community Nursing Unit OSV-0008706

Inspection ID: MON-0043975

Date of inspection: 10/03/2025

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
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Actions completed: There is a full schedule of mandatory training in place for 2025. Training deferred in January as a result of adverse weather events has been rescheduled and completed bringing compliance with mandatory training up to date. Staff training in managing residents BPSD continues and all care staff have had training in this area. There has been increased attention given to managing reactive behaviours including the introduction of CST to the activity program.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Actions completed: Records relevant to the residents' finances are located in the designated centre. There is an individual folder available for each resident. These are maintained with up to date statements of accounts, details of monies spent and itemized and are available for inspection. A care plan specific to the resident's individual financial requirements has been developed in conjunction with the resident and is available within the resident record. The patient private property form has been amended and now only reflects monies held where they have been handed in for safe keeping. Records of same are maintained. Valuables can be held for safe keeping for short periods in exceptional circumstances and this is managed by the clinical staff on the unit within the designated centre.	

Records required under Schedule 4 are available for inspection.

A full and complete record of all incidents involving residents is available for inspection.

The system in place for filing of records pertaining to the designated centre has been revised to enable efficient accessibility to requested records.

Actions to be completed:
The actions completed are in operation. Local policies and procedures and guidance documents review and drafting has commenced in line with the changes to practice and to reflect these revised local management arrangements.

Regulation 23: Governance and management	Not Compliant

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

Actions completed:
Clinical Nurse Management Structure: a recruitment campaign for CNM2 and CNM1 posts has just been completed to address the filling of vacant posts. Recruitment is actively progressing to fill those posts. Interim arrangements are in place to give assurances on supervision and oversight.

PPIM: The PPIM for the designated centre has been identified and documentation to support the application and the application form for PPIM has been submitted to the regulatory authority on 25th April 2025.

Management structure for residents' finances: A full overview of the management and record of residents finances has been completed under the following categories:

1.Oversight of management of records to include the storage of residents finances files within the designated centre and the streamlining of financial files into individual financial files. There is a folder for each resident to detail residents' monies and this is maintained within the designated centre. A meeting schedule is in place for the PIC to review each resident's records and to ensure that they have access to same.

2.Role and responsibility in relation to residents' property and monies within the designated centre have been clearly defined within the management structure. This has involved communication and education of staff in relation to the management of residents' monies and property.

3.Record management systems: The system in place for filing of records pertaining to the designated centre has been revised to enable efficient accessibility to requested records.

4.Risk management: The initial risk assessment in line with risk management policy has been reviewed and currently reflects the actions taken to mitigate the risk of non-compliance with the management of residents' finances in line with the regulations.

5. All changes in practice have been communicated, verbally and in writing, to all relevant staff.

Audits: Peer to Peer auditing is ongoing in the CNU. The respective Clinical Nurse Managers for the Units have been reminded of the need to ensure supervision and compliance in meeting required actions following auditing. Further refresher training has been provided to all nursing staff engaging with the auditing process, setting up follow up actions where needed and for ensuring the identified deficits are addressed. Monitoring of the outcomes of auditing has been added to the agenda for clinical governance meeting between CNM's and ADON's and during CNM meetings

Actions to be completed:
The actions in relation to record management systems have been completed and are in operation. Local policies and procedures and guidance review and drafting has commenced in line with the changes to practice and to reflect these revised local management arrangements. This review will include an auditing and monitoring component.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

Actions completed:
Records relevant to the residents' finances are located in the designated centre.
There is an individual folder available for each resident. These are maintained with up to date statements of accounts, details of monies spent and itemized and are available for inspection.

A process has commenced to ensure residents are informed of their statement balance on a monthly basis or as requested. This process will be guided by the care plan in place for each resident.

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:

Review of the residents care plans are undertaken at least 3 monthly or as required. All nursing staff have been reminded of the importance of ensuring that any changes made to the pathway of care for a resident are effectively communicated and documented. The CNM's on our units have responsibility to ensure that there is ongoing monitoring in compliance with this. Training in specific areas has been delivered to ensure that assessment tools are used effectively to identify potential deterioration and ensure appropriate referrals to other services to proactively manage identified risk. Nutritional assessment training has been undertaken through online training and face to face training sessions are booked for the 1st May 2025.

Regulation 9: Residents' rights	Not Compliant

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

Actions completed:
Records relevant to the residents' finances are located in the designated centre.
There is an individual folder available for each resident. These are maintained with up to date statements of accounts, details of monies spent and itemized and are available for inspection.

A care plan specific to the resident's individual financial requirements has been developed in conjunction with the resident and is available within the resident record.

Access to information about monies: Within the designated centre, there is an individual folder detailing monies available to each resident and spent, itemized, updated and presented to each resident on a monthly basis or as required for their own information. This process will be guided by the care plan in place for each resident.

Access to their own monies, Mon – Sunday: a process has been put in place to ensure access to residents' own monies at any time of the day for each resident. All staff are aware of this process and will facilitate access for the residents at their request.

Actions to be completed:
An information leaflet on how residents' monies are been managed by the service will be developed in conjunction with the residents. This will highlight how the service will support the rights of the residents their accessing their monies.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	24/04/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	24/04/2025
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	Not Compliant	Red	20/03/2025

	for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Red	20/03/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/07/2025
Regulation 23(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 details responsibilities for all areas of care provision.	Not Compliant	Orange	25/04/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	20/03/2025
Regulation 5(2)	The person in charge shall	Substantially Compliant	Yellow	24/04/2025

	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.			
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	24/04/2025
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Red	20/03/2025