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:	The Residence Portlaoise
Name of provider:	The Residence PL Limited
Address of centre:	Block B The Maltings, Harpur's Lane, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	12 February 2025
Centre ID:	OSV-0008667
Fieldwork ID:	MON-0045922

About the designated centre

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

The Residence Portlaoise is a purpose-built nursing home which consists of 101 single registered bedrooms with en suite bathrooms. The Residence Portlaoise is situated a short distance from the town of Portlaoise, therefore the Nursing Home is serviced by restaurants, public houses, local library, community hall, places of worship and also has easy transport links. The Residence Portlaoise accommodates male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older people who require nursing care, dementia care, palliative care, respite and post-operative care. There are a variety of communal day spaces provided including dining rooms, day rooms and visitor rooms available. Residents also have access to a large secure enclosed garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	70

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 12 February 2025	09:00hrs to 17:30hrs	Sean Ryan	Lead
Thursday 13 February 2025	10:00hrs to 16:15hrs	Sean Ryan	Lead
Wednesday 12 February 2025	09:00hrs to 17:30hrs	Catherine Sweeney	Support
Thursday 13 February 2025	10:00hrs to 16:15hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in The Residence Portlaoise told inspectors that they felt safe living in the centre and that staff were kind and polite to them. Staff were observed to be respectful towards residents. Overall, the feedback from residents was that, while staff supported them with their care needs, they sometimes experienced extended waiting times to receive assistance and support from staff. Residents attributed this to staff being busy and that there 'was not enough of them'.

Inspectors arrived unannounced at the centre and were met by the person in charge and a member of the regional management team, who was also a person participating in the management of the centre. Following an introductory meeting, inspectors walked through the centre and spent time observing the care provided to residents, talking to residents, visitors and staff, and observing the care environment. There was a calm, but busy atmosphere in the centre as staff were observed responding to residents' requests for assistance.

On the mornings of the inspections staff were observed answering call bells and assisting residents with their breakfast and tea in their bedrooms. Some residents were observed walking through the corridors independently, while other residents spent time in a large communal day room, chatting to one another about local news and events.

Inspectors spoke with a number of residents in their bedrooms. Residents were complimentary in their feedback about the staff, and described their engagements with staff as kind, respectful and caring. Residents acknowledged how busy the staff were and described how this impacted on the care they received. Two residents told inspectors that they frequently experienced difficulty in 'getting the attention of staff', either through using their call bell or calling out for assistance. They described how staff would respond to their call bell, but were interrupted during care to answer the call bells of other residents, or assist residents who were calling out. Residents told the inspectors that they would have to wait long periods of time for the staff to return and that they would have to use their call bell again to remind staff that they were waiting. Some residents said that while staff 'were lovely and did their best', there 'was not enough of them to help everyone', and they attributed this to the centre being short-staffed. Issues with this aspect of the service was also described by some relatives.

The centre provided accommodation over three floors and comprised of single bedroom accommodation. On the day of the inspection, residents were accommodated on all three floors of the centre.

Residents' bedrooms were personalised with items such as family photographs, colour-coordinated soft furnishings and ornaments. Residents told the inspector that

they were generally happy with their bedrooms, storage, and comfortable furnishings.

The centre was visibly clean throughout. Housekeeping staff were observed to clean the centre according to a schedule, and cleaning practices were observed to be consistent to ensure all areas of the centre were cleaned.

The residents dining experience was observed to be a pleasant, sociable and relaxed occasion for residents. Residents had a choice of meals from a menu that was updated daily. Staff were observed to provide assistance and support to residents in a person-centred manner.

Throughout the days of inspection, residents were engaged in a variety of group activities that included music and group exercises. The majority of residents attended the main day room on the ground floor. Some residents required the assistance of staff to engage in the activities, and staff were observed to provide that support in a kind and caring manner. However, some residents told the inspectors that, while their choice to not participate in group activities was respected, they were not provided with alternative individual activities. Residents stated that although they had provided information to staff about their interests and hobbies on admission, they did not have the opportunity to participate in activities, in accordance with their interests.

While there was a choice of comfortable and spacious communal rooms available to residents on each floor of the centre, residents were encouraged to spend their day in the ground floor day room, where staff would be available to support and supervise them. This room was observed to be crowded over the two days of the inspection.

Visiting was seen to be facilitated throughout the inspection. Inspectors spoke with relatives and friends of residents. Overall, visitors were complimentary of the premises and the staff. However, visitors described how they were not satisfied with some aspects of the service such as access to health care professionals and timely access into the centre when visiting. They expressed concerns that staff were 'always rushing', and while they admired the 'hard work' of staff, visitors told the inspectors that they often experienced long delays waiting to discuss residents' care needs with staff.

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

Capacity and capability

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

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- review monitoring notifications submitted by the provider to the Chief Inspector in relation to the safeguarding and protection of residents.
- review unsolicited information received by the Chief Inspector, pertaining to staffing and the quality of care, including health care provided to residents living in the centre.
- follow up on the actions taken by the registered provider to address the findings of non-compliance identified on the last inspection in October 2024.

The findings of this inspection were that the provider had failed to implement the compliance plans submitted following previous inspections of the centre, and findings of non-compliance were repeated on this inspection, with regard to the governance and management of The Residence Portlaoise. A weak organisational structure and ineffective management systems of monitoring and oversight continued to impact on the quality and safety of the care provided to residents. Inspectors found that, where the provider had implemented some systems to monitor aspects of the service including residents nutritional risks and access to health care, the provider failed to ensure that the implementation of those systems was consistent, effectively monitored and sustained. This resulted in repeated regulatory non-compliance in the regulations reviewed and impacted on the quality and safety of the care provided to residents.

Following the previous inspection on 24 October 2024, the registered provider was required to confirm the urgent actions they would take to ensure the safety and well-being of residents at risk of malnutrition, by dates specified by the Chief Inspector. Inspectors found that, while the provider had developed systems to oversee the nutritional care needs of residents assessed as being at high risk of malnutrition, it had failed to ensure that these systems were consistently maintained and effectively implemented.

Inspectors reviewed unsolicited information received by the Chief Inspector. The information received pertained to concerns regarding the governance and management of the centre, the organisation and management of the staffing resources, and the quality of care provided to residents. This information was found to be substantiated on this inspection.

The Residence PL Limited is the registered provider of The Residence Portlaoise. The registered provider is a company with four directors. One of the directors represented the registered provider in engagement with the Chief Inspector. Within the centre, the person in charge was supported by two assistant directors of nursing and a team of clinical nurse managers. Since the previous inspection, the registered provider had increased its presence in the centre with the additional attendance of the regional management team, comprising of a regional director, an associate regional director, and a quality team. The regional management team was responsible for monitoring clinical and non-clinical aspects of the service including compliance with record-keeping, staff training and ensuring that appropriate care pathways to meet the care and health care needs of residents. However, this

inspection found that the overall governance and management of the centre had deteriorated since the last inspection.

The management structure within the centre was not clearly defined. Lines of authority and accountability were not clearly identified. For example, the role of both the regional director and the associate regional director were not clearly described by the senior management team, and their role was not always distinct from the role of the person in charge. In addition, responsibilities of the person in charge were, at times, delegated to the assistant director of nursing and the clinical nurse managers. For example, it was unclear who held the responsibility for ensuring appropriate staffing levels were maintained in the event of unplanned staff leave. A lack of a clear procedure to escalate staffing risks to the provider or a pathway of action to manage unplanned staff leave compounded this risk. This impacted on the timely delivery of care, including social care to residents.

While staffing levels were appropriate on the days of inspection, a review of previously worked rosters evidenced nursing and health care staff levels were not consistently maintained. While the provider acknowledged that there were challenges in maintaining planned nursing and health care staff rosters, a risk assessment in relation to the impact of this had not been completed. This meant that there were no alternative arrangements to ensure the planned staffing levels were maintained.

As part of a compliance plan, submitted by the provider following a previous inspection, the provider had committed to implementing management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored. The provider had systems for monitoring the service in place. An electronic auditing system was available to facilitate auditing of both clinical and environmental aspects of the service. A review of this system found that, while some audits had been completed, there was no audit schedule in place. The rationale for how and why the management teams identified areas for monitoring and quality improvement could not be ascertained. In addition, some paper-based audits were being completed for areas such as care planning and call bell response times. However, the detail collected for these audits was poor, and there was no corresponding action plan completed to address any deficits found.

The previous inspection identified issues with inadequate oversight of residents nutritional risk in the centre. Inspectors reviewed the oversight of this aspect of care on this inspection and found that there was little evidence that the oversight of this issue had been strengthened. A review of completed nutritional audits did not provide assurance that there was an effective system in place to identify, monitor, and manage residents nutritional care needs and nutritional risks. For example, the audit had failed to identify potential contributing factors to the poor quality of nutritional care provided to residents, such as deficits in the knowledge of staff, and the poor quality of the clinical care records. As a result, the registered provider had failed to identify the significant deficits in the care of residents who were assessed as being at risk of malnutrition.

The provider had also committed to implementing a system to ensure that records were maintained in line with the requirements of the regulations. Inspectors found that this system was ineffective. Information pertaining to residents diagnostic tests, staff training, complaints, and resident nutritional monitoring were not appropriately maintained. Inspectors found that nursing notes were duplicated from previous entries and therefore did not include information pertinent to any changes to residents' well being or care plan. Additionally, records were not maintained in a manner that was accessible. Repeated requests for information and records were made over the two days of the inspection, and some records were not made available for review.

Despite being identified on a previous inspection, the provider had failed to identify risks associated with ineffective governance and systems of management to ensure that a quality, consistent and safe service was provided to residents. The provider had not appropriately identified the risk or contributing factors such as the high rate of staff unplanned leave or the high rate of weekly admissions to the centre. This impacted on the provider's ability to identify, monitor and manage risks to residents' safety and welfare.

The management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner. Inspectors found information, consistent with a complaint regarding the service, contained within the nursing records and surveys regarding the quality of the service. This information had not been recorded in the centre's complaints register. Consequently, there was no record of these issues being acknowledged, investigated or resolved to the satisfaction of the complainant.

A review of staff training records evidenced that all staff had up-to-date training appropriate to their role. The provider had previously committed to the provision of training for staff in relation to the nutritional assessment and monitoring of residents, complaints management, and care planning. While internal training had been scheduled in these areas, the content of these training sessions was not available for review, to confirm if they were appropriate. Staff knowledge of these areas of care had not been evaluated by the provider.

Inspectors found that the arrangements in place to supervise and support staff were not effective. For example, staff were not appropriately supervised to ensure residents received safe and quality care, in line with their assessed needs. Supervision of nursing documentation was also inadequate and did not ensure that accurate records of the care provided were maintained.

Regulation 16: Training and staff development

Staff were not appropriately trained to deliver effective and safe care to residents. For example, the provider did not monitor the effectiveness of training provided to staff to ensure staff were appropriately trained. When spoken with, some staff did not demonstrate an appropriate level of knowledge to identify and address the

nutritional needs of the residents. While staff had completed training specific to nutrition, they demonstrated a poor awareness of the assessment of residents' nutritional care needs, and the pathway of care to take in response to a resident's risk of malnutrition.

Staff were not appropriately supervised. This was evidenced by inadequate supervision of staff to ensure;

- residents clinical documentation, including the assessment of residents needs and care planning, to ensure they were accurate and up-to-date.
- communication of key clinical information to staff to ensure care was delivered in line with the residents assessed needs and care plans.
- records including nursing, medical and complaints to ensure they were maintained, in line with the requirements of the regulations.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

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

- Records of specialist treatment, nutritional care and nursing care provided to residents were not appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records pertaining to the nutritional care of a resident was not available for review.
- Nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that nursing notes were duplicated from previous entries over a seven day period. This meant that the record was not person-centred, and did not provide assurance that the daily care needs of the residents had been met.
- Records of on-going medical assessment, treatment and care were not consistently maintained, as required by Schedule 3(4)(e) of the regulations. For example, records of three residents' diagnostic test results were not maintained in the centre, or available to staff for review.
- Record of complaints made by residents and their families, and the action taken by the registered provider in respect of any such complaint were not always maintained, in line with the requirements of Schedule 4(6).
- Records were not kept in a manner as to be accessible. Repeated requests for records were made throughout the inspection, and some requested records were presented in a disjointed and disorganised manner. This included records pertaining to the systems of risk and incident management, complaints, medical and nursing care records.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that staffing resources in the centre were planned and managed to ensure person-centred, effective and safe services. The registered provider had failed to ensure that the service had sufficient staffing resources to maintain adequate and planned nursing staff and health care staff levels.

The registered provider had failed to ensure that there was a clearly defined management structure in place, with clear lines of accountability and responsibility, in line with the centre's statement of purpose. Accountability and responsibility for key aspects of the service such as the oversight and management of the staffing resources, management of risk, oversight of clinical care, and quality assurances systems in the centre were unclear. Consequently, there were poor systems in place to escalate risk to the registered provider and resulted in poor outcomes for residents.

Inspectors found that the management systems were ineffective to ensure a safe, monitored and consistent service was provided. This was evidenced by;

- ineffective systems of communication to facilitate the escalation of key information about the service to the provider. Records of senior management team meetings evidenced that information regarding key performance indicators, such as open complaints, admission rates and resident falls were not analysed or interrogated for further review and action.
- ineffective auditing systems. For example, weekly nutritional care plan audits commencing 1 December 2024 did not include detail of the findings of the audit, therefore no analysis or learning had been identified. This meant that no quality improvement plan was developed to ensure residents' nutritional care needs, and nutritional risks were appropriately identified, monitored, and managed.
- ineffective systems to ensure key clinical information regarding residents' care needs were effectively communicated to staff. For example, all staff were not informed of changes to residents care and support needs following nursing and medical reviews. Staff were unaware that a resident a high risk of malnutrition had been reviewed by a dietitian in January 2025. Consequently, the interventions prescribed by the health care professional to manage residents nutritional risk were not completed. This posed a significant risk to the care and welfare of residents and impact on the quality of care provided.
- ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and

health care services, and implementing the recommendations of health care professionals.
- poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to nursing documentation, and the records of residents' medical reviews.
- poor oversight of the centre's complaints management system, and escalation of complaints, to ensure complaints were managed in line with the requirements of the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were not recorded and managed in line with the centre's own policy and the requirements of the regulation. Not all complaints or expressions of dissatisfaction with the service had been documented. This meant that there was no documentation of how these issues were acknowledged, investigated or if the complaints had been resolved to the satisfaction of the complainant, as required under Regulation 34. For example, multiple residents and their families had reported dissatisfaction at the length of time it took to have the front door answered over a four month period in 2024. While some action had been taken by the provider in recent months, these complaints were not documented and managed through the centres own complaints management system.

In addition, inspectors were informed by families that they had communicated complaints to the staff in the centre, however, these complaints were not documented.

This is a repeated non-compliance.

Judgment: Not compliant

Quality and safety

While the day-to-day interaction between residents and staff was kind and respectful throughout the inspection, inspectors found that the quality and safety of care provided to residents was compromised as a result of ineffective systems of governance and management described in the capacity and capability section of this report. The continued failure of the provider to implement effective quality assurance systems and clinical oversight posed an ongoing risk to residents in the

centre, with regard to residents' nutritional care needs, their individual assessments and care plan, and timely access to health care.

The provider had taken some action to improve the quality of the nursing documentation with regard to the residents' individual assessment and care plans. While there was evidence that residents' needs had been assessed using validated assessment tools, the care plans reviewed were not always informed by these assessments, and did not fully reflect person-centred guidance on the current care needs of the residents. Furthermore, not all care plans were reviewed and updated as the residents' condition changed. Consequently, inspectors found that the needs of residents were not always known to the nursing and care staff.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs. However, some residents were not provided with appropriate access to health care professionals, despite showing signs of deterioration. In addition, some residents were not provided with timely referral and access to specialist health care services for further expert assessment, despite this being indicated within their medical and nursing notes.

Following the findings of the last inspection, an urgent review of food and nutrition was completed by the provider. The provider had taken some action to ensure residents, who were at risk of malnutrition, were identified through appropriate clinical assessment. Arrangements had been made for residents to access the expertise of health care professionals such as dietetic services and speech and language therapists for further expert assessment. However, inspectors found that the recommendations made by these professionals was not always implemented or communicated to the relevant support service.

The procedure to safeguard residents was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents, should a safeguarding concern arise. However, this inspection found the systems of training and support in place for staff were not fully effective and not in line with the centre's own safeguarding policy.

Residents told the inspectors that they felt safe living in the centre and that staff treated them with dignity and respect. Residents were satisfied with the arrangements in place for them to access religious services. Residents were provided with access to daily newspapers, television and radio.

Residents also reported that their right to exercise choice was impacted upon by the availability of staff. For example, residents reported waiting extended periods of time to receive assistance and support from staff. Residents also told inspectors that they were encouraged to spend the day in a ground floor day room so that they could be supervised by staff. Residents were not facilitated to chose to use any of the other available day room spaces.

An activity schedule was displayed and residents were observed to be participating in group activities such as daily exercises and music. However, residents told the inspectors that their access to the activities programme was restricted to group

activities in the ground floor day room and that this was dependent on the availability of staff.

Regulation 5: Individual assessment and care plan

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

- Care plans were not informed by a comprehensive assessment of the residents care needs. For example, some residents' care plans did not accurately reflect the needs of the residents and did not identify interventions in place to support residents when identified with clinical risk factors. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. For example, a care plan to support a resident's increased monitoring and supervision needs at meal times was not appropriately reviewed or updated following return from the acute services. Therefore, staff did not have the required information to safely support the resident's care needs.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

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

- provide a resident with timely and appropriate referral to health care professionals, such as dietetic services for further assessment and expertise when clinically indicated, in line with the residents care plan.
- ensure arrangements were in place to provide timely health care and diagnostics in line with the recommendations of health care professionals.
- ensure arrangements were in place to implement the recommendations and interventions prescribed by health care professionals following expert assessment. For example, the recommendations made following assessment by speech and language and dietitian professionals were not appropriately implemented.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 8: Protection

The provider had failed to ensure that staff were appropriately trained and supported to implement the centre's own safeguarding policy, which was underpinned by national best practice guidelines.

This is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents reported that their right to exercise choice was impacted by the availability of staff. Residents explained that they could not use all the available communal spaces in the centre due to the lack of staff availability to supervise residents.

The inspectors observed that a number of residents remained in their bedrooms and did not take part in activities. When asked, residents told inspectors that the group activities programme did not suit their interest or capabilities and as a result, they choose not to attend the communal areas. Residents reported that the provision of one-to-one activities was dependent on the availability of staff. A review of the activities records confirmed that some residents had not been provided with opportunities for social engagement for a period of six weeks.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for The Residence Portlaoise OSV-0008667

Inspection ID: MON-0045922

Date of inspection: 13/02/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A review and update of training materials specifically in areas of complaints, risk management, nutrition and care planning has been undertaken by the Head of Quality and Quality Manager for Care- complete

Updated training has commenced for all clinical staff in the areas of complaints, risk management, nutrition and care planning. Included in this training is a clear outline of the pathway of care to be delivered to residents at risk of malnutrition. The training is currently being delivered by the Quality Manager for Care and will be completed by 30th April 2025.

Additional dysphagia and MUST training will be delivered to all staff in the home by a certified SALT and Dietician by 30th May 2025.

By 30th May 2025, an evaluation of the training delivered to staff will be completed, including assessment of knowledge and understanding in the areas of care planning, complaints management, risk management and nutrition.

An additional clinical nurse manager post is currently being recruited. This post will further enhance supervision of clinical staff and support evidence-based clinical decision making, assessment and care planning, maintenance of all required records and communication of key clinical information. The postholder will be in place by 30th May 2025. In the interim, a supernumerary CNM and ADON are present on all day shifts, including the weekend. Regular night governance visits are conducted by the PIC to ensure that supervision on night duty is appropriate.
A review of roles and responsibilities of clinical managers has been completed to ensure

clinical manager presence at handovers, consistent daily supervision of staff and residents and to provide clinical support, robust oversight of all care delivered, records maintained and appropriate communication of key clinical information daily. This is included on a daily walkabout checklist for all clinical managers- complete

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A new process has been implemented to ensure that all relevant information regarding referrals, diagnostic test and results and recommendations from all members of the MDT are recorded and communicated across the team, in a timely manner- complete.

Records of all MDT referrals and outcomes, including diagnostic test and results are now recorded in the electronic care management system and staff are currently receiving training on the use of this tool. Training will be fully completed by 30th April 2025.

Care plan training has been reviewed and updated is being delivered by the Quality Manager for Care to ensure documentation of care is reflective of the assessed needs of the resident and is individualised and person centred. This training will be completed by 30th April 2025.

From 17th February 2025, the PIC is reviewing a weekly report of progress notes to ensure that these records are person centred and reflective of care delivered.

A full review of current complaints is underway to ensure that they are managed and documented appropriately and in line with our policy and regulatory requirements. This review will be completed by the PIC by 24th March 2025.

A 6 month review of complaints (September 2024 to February 2025) is also underway by the Quality Manager for Care. This will be completed by 30th April 2025 to ensure all complaints during this period have been managed and documented in line with policy and regulatory requirements and that lessons learned have been identified and shared,.

A review of the current systems, audits and processes has commenced with the objective of strengthening and streamlining risk management, clinical oversight and records management and to ensure that records are accurate, easily retrievable and in line with regulatory requirements - this review will be completed by 30th March 2025 and actions will be in place by 30th April 2025.

Regulation 23: Governance and management	Not Compliant

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

A new PIC will commence in the home on 24th March 2025.

An additional clinical nurse manager post is currently being recruited. This post will further enhance supervision of clinical staff and support evidence-based clinical decision making, assessment and care planning, maintenance of all required records and communication of key clinical information. The postholder will be in place by 30th May 2025. In the interim, a supernumerary CNM and ADON are present on all day shifts, including the weekend. Periodic night governance visits are also conducted by the PIC to ensure that supervision on night duty is appropriate.

A review of roles and responsibilities of clinical managers has been completed to ensure clinical manager presence at handovers, consistent daily supervision of staff and residents and to provide clinical support, robust oversight of all resident care delivered, records maintained and appropriate communication of key clinical information daily. This is included on a daily walkabout checklist for all clinical managers- complete

An SOP has been approved and implemented to ensure that the allocation of staff is appropriate during episodes of unplanned absence and to ensure that ongoing review and oversight of resident needs continues to inform decision making regarding any additional staffing resources required. Clinical nurse managers are aware of the escalation protocol to ensure that adequate resources are available at all times- complete.

From 14th February 2025, the Quality Department is supporting the implementation of an agreed Quality Improvement Plan and is interrogating risk management and clinical data reported by the home. This arrangement will identify clinical risks and areas for improvement in a timely manner. This oversight will be completed weekly for sentinel events and monthly for an agreed dataset of quality indicators (falls, deaths, mortality, hospital transfers, medication errors, restraints, complaints, incidents, weight loss) and will be cross-referenced with specific resident care plans and care records.

From February 14th, 2025, the COO and/or the Head of Quality will attend the monthly governance meeting to ensure robust review and interrogation of all quality indicators, referrals, complaints and incident analysis, audit findings and action plans and dissemination of learning to staff. This arrangement will be reviewed following the review of findings of a compliance audit to be completed by 31st May 2025.

Audit and supervision training for CNMs and ADONs commenced on 12th March 2025 to ensure items identified for improvement are identified, actioned and that follow up is completed to close actions in the agreed timeframe. This training will be completed by 30th March 2025

A new process has been implemented to ensure that all relevant information regarding referrals, diagnostic test and results and recommendations from all members of the MDT are recorded and communicated across the team, in a timely manner- complete.

Records of all MDT referrals and outcomes, including diagnostic test and results are now recorded in the electronic care management system and staff are currently receiving training on the use of this tool. Training will be fully completed by 30th April 2025.

A 6 month review of complaints (September 2024 to February 2025) is also underway by the Quality Manager for Care. This will be completed by 30th April 2025 to ensure all complaints during this period have been managed and documented in line with policy and regulatory requirements and that lessons learned have been identified and shared,.

A review of the current systems, audits and processes has commenced with the objective of strengthening and streamlining risk management, clinical oversight and records management and to ensure that records are accurate, easily retrievable and in line with regulatory requirements - this review will be completed by 30th March 2025 and actions will be in place by 30th April 2025.
Care plan training has been reviewed and updated is being delivered by the Quality Manager for Care to ensure documentation of care is reflective of the assessed needs of the resident and is individualised and person centred. This training will be completed by 30th April 2025.

From 17th February 2025, the PIC is reviewing a weekly report of progress notes to ensure that these are person centred and reflective of care delivered.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A full review of current complaints is underway to ensure that they are managed and documented appropriately and in line with our policy and regulatory requirements. This review will be completed by the PIC by 24th March 2025.

A 6 month review of complaints (September 2024 to February 2025) is also underway by the Quality Manager for Care. This will be completed by 30th April 2025 to ensure all complaints during this period have been managed and documented and that lessons learned have been identified and shared, in line with policy and regulatory requirements.
A review and update of training materials specifically in the area of complaints has been undertaken by the Head of Quality and Quality Manager for Care- complete

Additional and updated training has commenced for all clinical staff in the area of complaints. The training is currently being delivered by the Quality Manager for Care and will be completed by 30th April 2025.

By 30th May 2025, an evaluation of the training delivered to staff will be completed, including assessment of knowledge and understanding in the areas of complaints management.

From 1st March 2025, a CAMEO Café with families and residents to raise awareness of complaints policy and to address any immediate concerns will take place on a monthly

basis to encourage communication and feedback within the home.

From February 14th, 2025, the COO and/or the Head of Quality will attend the monthly governance meeting to ensure robust review and interrogation of all quality indicators, referrals, complaints and incident analysis, audit findings and action plans and dissemination of learning to staff. This arrangement will be reviewed following the review of findings of a compliance audit to be completed by 31st May 2025.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A review and update of training materials specifically in the area of assessment and care planning has been undertaken by the Head of Quality and Quality Manager for Care- complete

Additional and updated training has commenced for all clinical staff in the area of assessment and care planning. The training is currently being delivered by the Quality Manager for Care and will be completed by 30th April 2025.

By 30th May 2025, an evaluation of the training delivered to staff will be completed, including assessment of knowledge and understanding in the areas of assessment and care planning.

A review has been completed of all current residents. This review was to ensure a comprehensive assessment and person-centred care plan is in place including MDT referrals, where appropriate, timely updates reflecting changes in condition and participation in social activities and that all recommendations have been actioned- complete

A new process has been implemented to ensure that all relevant information regarding referrals, diagnostic tests and results and recommendations from all members of the MDT are recorded and communicated across the team, in a timely manner- complete.

From 14th February 2025, the Quality Department is supporting the implementation of an agreed Quality Improvement Plan and is interrogating risk management and clinical data reported by the home. This arrangement will identify clinical risks and areas for improvement in a timely manner. This oversight will be completed weekly for sentinel events and monthly for an agreed dataset of quality indicators (falls, deaths, mortality, hospital transfers, medication errors, restraints, complaints, incidents, weight loss) and will be cross-referenced with specific resident care plans and care records.

From 17th February 2025, the PIC is reviewing a weekly report of progress notes to ensure that these are person centred and reflective of care delivered.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A review has been completed of all current residents. This review was to ensure a comprehensive assessment and person-centred care plan is in place including MDT referrals, where appropriate, timely updates reflecting changes in condition and participation in social activities and that all recommendations have been actioned- complete

A new process has been implemented to ensure that all relevant information regarding referrals, diagnostic test and results and recommendations from all members of the MDT are recorded and communicated across the team, in a timely manner- complete.

Records of all MDT referrals and outcomes, including diagnostic tests and results are now recorded in the electronic care management system and staff are currently receiving training on the use of this tool. Training will be fully completed by 30th April 2025.

A review of roles and responsibilities of clinical managers has been completed to ensure clinical manager presence at handovers, consistent daily supervision of staff and resident care and to provide clinical support, robust oversight of all resident care delivered, records maintained and appropriate communication of key clinical information daily. This is included on a daily walkabout checklist for all clinical managers- complete

From February 14th, 2025, the COO and/or the Head of Quality will attend the monthly governance meeting to ensure robust review and interrogation of all quality indicators, referrals, complaints and incident analysis, audit findings and action plans and dissemination of learning to staff. This arrangement will be reviewed following the review of findings of a compliance audit to be completed by 31st May 2025.

From 14th February 2025, the Quality Department is supporting the implementation of an agreed Quality Improvement Plan and is interrogating risk management and clinical data reported by the home. This arrangement will identify clinical risks and areas for improvement in a timely manner. This oversight will be completed weekly for sentinel events and monthly for an agreed dataset of quality indicators (falls, deaths, mortality, hospital transfers, medication errors, restraints, complaints, incidents, weight loss) and will be cross-referenced with specific resident care plans and care records.

Access to regular GP and physiotherapy services has been secured and staff are clear on the importance of escalating any interruptions to planned service so communication with residents is timely and sessions can be rescheduled- complete

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Refresher training for all clinical managers will be provided on the sequence of actions to be taken in the event of an allegation, suspicion or actual abuse occurring in the centre. This training will be completed by 30th April 2025.

A review of current residents to ensure all reported incidents have been addressed in line with policy and regulatory requirements has been completed.

Safeguarding training content is currently under review by Head of Quality and lead Regional Director for Safeguarding to ensure it is in line with local policy and national guidelines. The review will be completed by 30th April 2025 and following this will be rolled out to all staff, in line with our mandatory training matrix.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A review of roles and responsibilities of clinical managers has been completed to ensure clinical manager presence at handovers, consistent daily supervision of staff and residents and to provide clinical support, robust oversight of all resident care delivered, including activities, records maintained and appropriate communication of key clinical information daily. This is included on a daily walkabout checklist for all clinical managers- complete
An SOP has been approved and implemented to ensure that the allocation of staff is appropriate during episodes of unplanned absence and to ensure that ongoing review and oversight of resident needs continues to inform decision making regarding any additional staffing resources required. Clinical nurse managers are aware of the escalation protocol to ensure that adequate resources are available at all times to ensure residents have adequate supervision and can attend activities in line with their will and preference- complete.
An additional clinical nurse manager post has been approved and is currently being recruited. This post will further enhance supervision of clinical staff and support evidence-based clinical decision making, assessment and care planning, maintenance of all required records and communication of key clinical information, including resident preferences for activities and their participation. The postholder will be in place by 30th May 2025. In the interim, a supernumerary CNM and ADON are present on all day shifts, including the weekend. Regular night governance visits are conducted by the PIC to ensure that supervision on night duty is appropriate.

Our group lead in activities will complete an audit and support the team and residents together in devising a revised plan for activities, ensuring it is appropriate to residents' abilities, will and preferences. Part of this audit will be receiving resident feedback and comments for improvement. A programme for one to one activity provision will also be reviewed and implemented at this stage. The audit will be completed by 30th March 2025 and the programme will be implemented by 14th April 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	30/05/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/05/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/04/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre	Substantially Compliant	Yellow	31/05/2025

	has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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	31/05/2025
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	Orange	31/05/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly	Not Compliant	Orange	31/05/2025

	recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/05/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/05/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based	Not Compliant	Orange	31/05/2025

	nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Orange	31/05/2025
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	31/05/2025
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	30/04/2025
Regulation 9(2)(b)	The registered provider shall provide for	Substantially Compliant	Yellow	30/05/2025

	residents opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/05/2025