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:	Esker Lodge Nursing Home
Name of provider:	Esker Lodge Limited
Address of centre:	Esker Place, Cathedral Road, Cavan
Type of inspection:	Unannounced
Date of inspection:	24 April 2026
Centre ID:	OSV-0000135
Fieldwork ID:	MON-0048203

About the designated centre

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

The designated centre provides care and support to meet the needs of both male and female older persons. It provides twenty-four hour nursing care to 70 residents both long-term (continuing and dementia care) and short-term (convalescence and respite care). The philosophy of care is to provide excellence in the delivery of compassionate care to residents. The centre is a three storey building located in an urban area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	69

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
Friday 24 April 2026	09:00hrs to 17:00hrs	Michael Dunne	Lead
Friday 24 April 2026	09:00hrs to 17:00hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors observed that residents were supported to enjoy a good quality of life, supported by a team of staff who were kind, caring, and responsive to their needs. The feedback from residents was that they were happy with the care they received, and that staff looked after them very well. All residents who spoke with the inspectors said that they felt safe and secure living in the centre, and that if they had a concern, they could raise this with any member of the team.

One resident told the inspectors that " staff look after me very well", while another resident said that " staff look after my room and clean it for me because I am not able to do it for myself". Inspectors also spoke with visitors who attended the centre on the day, and their feedback was positive regarding the quality of care provided to their relatives.

Upon arrival, the inspectors completed the sign-in process, and were greeted by the assistant director of nursing (ADON). The person in charge was attending an external meeting at this time, but was due to arrive at the centre later in the morning. The inspectors commenced a walk around of the designated centre, where they had the opportunity to meet residents and staff as they began preparations for the day. There were 69 residents living in the centre on the day of the inspection. A short time later, the inspectors met with the person in charge and shortly after that with a director of the company. The inspectors discussed the purpose of the inspection, which included a review of the provider's compliance plan arising from the previous inspection held in May 2025. The inspectors also gave verbal feedback on their findings arising from the walkabout. Following the introductory meeting, the inspectors reviewed several care records and the documentation that they had requested earlier.

During the walk around of the centre, the inspectors observed that staff were busy attending to residents' personal care needs. This support was provided in a discreet and respectful manner, mindful of residents' autonomy. Several staff and residents' interactions were observed, residents who presented with communication needs were supported by staff in a positive manner. Residents were given time and space to make their views known. These interactions confirmed that staff were aware of residents' assessed needs, and were able to respond to those needs in a constructive manner. Residents who walked with purpose were supported by staff in a dignified manner, and this approach was seen to reduce potentially challenging situations and maintain the safety of those residents. Although, one resident was observed entering other residents rooms uninvited, and this was communicated to staff, who assisted the resident back to their own room.

Residents’ bedrooms that were viewed by the inspectors appeared clean, contained storage, and were decorated with personal items. Inspectors found that while

wardrobes and cupboards were provided, a small number were not always located within the individual bed space of some residents. These arrangements did not ensure that residents have ready and private access to their personal possessions. This furniture arrangement can also create Infection Prevention and Control (IPC) risks. There were ongoing decoration works in the centre to improve the environment. However, the inspectors noted that some items of furniture, doors, and wall surfaces were still scuffed and damaged. Because these surfaces are no longer smooth or impermeable, they cannot be effectively cleaned. The provision of suitable premises and infection control are interdependent. A small number of pillows were worn, some were stained, and and some were in need of cleaning or replacement.

The organisation of storage required strengthening as inspectors found that some items were inappropriately stored in the same space, such as resident equipment, and resident supplies. For example; resident incontinence wear and unmarked toiletries were stored in shared bathrooms, while an unclean mattress pump was stored in the linen store along with clean linen. These practices can lead to cross contamination. Despite these observations, there was a good standard of cleaning observed on the day of inspection.

Besides the areas identified as requiring attention, the majority of the designated centre was tastefully decorated for the benefit of residents. There were flowers and colourful paintings located throughout the centre to enhance the lived environment. The provider had redesigned the sensory room, and this space appeared calm and welcoming for the residents. Sitting rooms were spacious, and contained a range of seating to meet the assessed needs of the residents.

There was unrestricted access to the garden area located off the Dun A Ri unit. This area contained level pathways to promote easy access for residents using mobility aids. The provider was in the process of planting flowers, and other plants to add to the existing shrubbery located in this area. However, the seating in this space required cleaning so that it could be used safely by the residents who wished to use this resource. The provider had improved access to the roof terrace, which contained flowers, seating, and murals, which provided an additional external space for residents to use.

There was a well-planned schedule of activities available in this centre, that was advertised in all of the units, and was made available for residents in their bedrooms. On the day, activities consisted of a pet therapy visit, nail, and beauty care, bingo, discussions about topics in the news, and about events in the local area. A mass service was streamed daily into the centre, while a priest visited the centre every second Thursday. The inspectors spoke with several residents who wished to remain in their rooms who expressed their delight to receive the pet therapy dog which appeared to lift their spirits. Several residents were observed chatting with each other, and they appeared happy and content in their lived environment.

Residents' dietary requirements were well-catered for. There was a choice of menu available for residents on the day, which included a roast pork and a breaded cod

dish. There were various options for residents who did not like what was on the menu. The main tea options consisted of chicken Maryland or a ham salad, while other options were also available for residents who did not prefer these meals. Residents said that the quality of food is always good, and that they enjoyed the dining experience. Residents who required support with their eating and drinking were provided with timely assistance to enjoy their meal. The inspectors observed a meal service, and found it to be well-organised, and appropriate for the assessed needs of the residents living in the designated centre.

The next two sections of this report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance judgements are set out under each regulation.

Capacity and capability

This is a well-managed centre that ensures that residents were provided with good standards of care to meet their assessed needs. For the most part, there were effective management systems in place, which provided effective oversight to maintain these standards. The management team were proactive in response to issues identified through audits with a focus on continual improvement. There were, however some areas of current practice that required additional actions to ensure compliance with the regulations. These issues are discussed in more detail under the relevant regulations relating to governance and management, premises, infection control, records, and fire precautions.

This was an unannounced inspection carried out to review compliance with the regulations, and to follow up on actions the registered provider had agreed to implement in order to achieve compliance with the regulations arising from the inspection carried out in May 2025. This inspection also focused on the provider's compliance with regard to the management of infection prevention and control in the designated centre.

The provider of Esker Lodge Nursing Home is Esker Lodge Limited. The centre has a clearly defined management structure, which consists of the registered provider representative, who is a director of the company, the person in charge, the assistant director of nursing (ADON), a clinical nurse manager (CNM), and a senior staff nurse. The remainder of the team consists of staff nurses, housekeeping, catering, administration, maintenance, and activity support.

This inspection found that the provider had implemented their compliance plan arising from the last inspection. A review of resident rooms found that residents now had easy access to their call-bells. Residents had unhindered access to their roof terrace, and overall, storage had improved, but there were still areas that required

attention. In addition, Closed-Circuit Television (CCTV) was only located in areas to monitor corridors, including points of entry and exit.

The quality and safety of care were monitored through a schedule of audits, including infection prevention and control. The majority of audits had captured some of the findings observed on the day by inspectors. For example; flooring repairs required, sharps management and storage. However, some audits had not captured findings that required additional focus, and therefore, did not have an action plan in place to address or mitigate the associated risks. The issues concerned are discussed further under the relevant regulations.

On the whole, there were arrangements to maintain care records in a safe and secure manner. There was a focus on ensuring that residents were made aware of key events in the centre and the services that are available. The provider made available information about the centre, including the Residents' guide and the activities schedule, in all of the residents' bedrooms. However, a review of this information found that there was also personal information included. This information was available in twin rooms, which compromised residents' confidentiality

The registered provider maintained sufficient staffing levels, and an appropriate skill-mix across all of the units to meet the assessed needs of the residents. This finding was reinforced by feedback from residents and visitors. The registered provider ensured there was a well-structured, and effective communication systems in place between staff and management that included daily handover meetings (the formal process of transferring job responsibilities, ongoing tasks, and critical information from one employee to another), clinical governance meetings, and regular staff meetings. For the most part, meeting records identified improvement actions and identified the person responsible to oversee that these actions were implemented.

There was an annual review of quality and safety in place, which incorporated the views of residents and their families for 2025. This document also included a quality improvement plan for 2026, which the provider was working through at the time of this inspection.

Records confirmed that there was a high level of training provided for staff in this centre. In addition to the provision of mandatory training in fire safety, patient moving and handling, safeguarding and infection control training. Staff had also access to a range of supplementary training to support them in their roles. For example, records confirmed that staff had access to training in person-centred care, falls prevention, diet and nutrition, dementia, and end of life. In addition, there was a range of training provided for clinical staff that included training on the treatment of pressure ulcers, dysphagia, nutrition screening, and wound management.

The provider ensured that training was available for staff to promote the rights of the residents living in the designated centre. Available training in this area included equality, diversity and inclusion, human rights training with a focus on the FREDA principles of fairness, respect, equality, dignity and autonomy. Discussions with staff

during the course of the day confirmed that they were aware of their individual and collective role, and on how they would promote the rights of the residents living in the designated centre.

A review of complaints records found that complaints were investigated in accordance with procedures set out in the designated centre's complaints policy. Records were well-maintained, and there was oversight and evaluation of complaints in the centre in order to drive service improvement.

Regulation 15: Staffing

There were sufficient staff on duty on the day of the inspection to meet the needs of the residents. Rosters showed that there were always a minimum of two nurses on duty in the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to regular and refresher training to ensure their mandatory training was up to date. All staff were up-to-date with their fire safety, moving and handling and safeguarding training. Records showed that staff had access to infection prevention and control updates, and training included the standards for the prevention and control of health care-associated infections published by the Authority.

The inspectors noted that staff appraisals were in place, supporting a culture of continuous professional development and accountability.

Judgment: Compliant

Regulation 21: Records

Inspectors found that personal information about residents residing in a twin room was also stored along with information about the centre, and was therefore available for visitors, or relatives who may visit that room to read.

This issue was brought to the attention of staff who were in attendance, who were advised to remove the personal information about these residents as it could negatively impact their privacy, and confidentiality.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that the registered provider had management systems in place to monitor the quality of the service provided; however, some actions were required to ensure that these systems were sufficient to ensure the services provided are safe, appropriate and consistent. For example:

- The systems to identify, and oversee risks were not fully effective as several risks were identified on inspection that did not have an appropriate risk assessment in place to mitigate these risks. These risks are described in more detail under the relevant regulations for fire precautions, premises, infection control, and records.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A review of a number of contracts for the provision of services confirmed that residents had a written contract of care that outlined the services to be provided, and the fees to be charged, including fees for additional services.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members to lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion.

A review of the complaint's log indicated that the provider had managed the complaints in line with the centre's complaints policy.

Judgment: Compliant

Quality and safety

Overall, the residents enjoyed good quality of life, care and support from a staff team who knew them well. This helped to ensure that care was person-centred and that daily routines were flexible. There was a relaxed and welcoming atmosphere in which residents could spend time socialising together, or with their families and friends. Residents were found to be comfortable in their lived environment.

Inspectors found that there was effective maintenance of residents' care records, and in the development of person-centred care plans. Care interventions were specific to the individual concerned, and were updated, as and when residents' needs changed, or on a four-monthly basis in line with the regulations. There was evidence of consultation and involvement with the resident's nominated representative when the resident was unable to participate fully in the care planning process. The narrative in residents' progress notes was comprehensive, and directly related to the agreed-upon care plans interventions. The sample of care plans reviewed by inspectors included pre-admission IPC assessments, documentation for multi-drug resistant organisms (MDROs), and catheter care, all of which were consistent with national guidelines.

A small number of residents were in receipt of personal assistant support (PA), which provides additional support to individuals with physical, sensory, or intellectual disabilities. The inspectors observed PAs attending the service, and supporting residents in the centre while others were observed taking residents out for trips to the local community.

Residents had access to a range of health care services, which included a general practitioner (GP) service, and arrangements for out-of-hours medical support. There were arrangements in place for residents to access health and social care professionals, including dietitians, speech and language therapists, and tissue viability nursing (TVN) to provide support with wound care if required. There were networks in place to access additional expertise from the local acute centre and from specialist teams in the community, such as public health.

The National Transfer Document and Health Profile for Residential Care Facilities used when residents were transferred to the hospital. This document contained details of health-care associated infections, and colonisation to support the sharing of and access to information within and between services. Where the resident was temporarily absent from the designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital, and health and social care professionals.

Several staff and resident interactions were observed by the inspectors, and were found to be supportive and positive. The provider had maintained good levels of

communication with residents, ensuring that they were kept up-to-date regarding key events in the home. Resident meetings were informative and covered topics such as resident care, food, and catering, resident activities, and infection prevention and control issues. In addition to the structured resident meetings, the provider kept residents informed either verbally or through regular written communication. Residents' right to privacy and dignity were respected, staff were observed to knock on residents' doors prior to entry, and explained to the residents the purpose of their visit. There were opportunities for residents to engage in the activity programme in-line with their interest and capabilities. Residents were seen to engage in planned activities throughout the day, while other residents pursued their own individual interests either in communal areas or in their own rooms.

The provider had taken precautions against the risk of fire in order to protect residents in the event of a fire emergency. A number of records relating to fire safety were found to be well-maintained. These records included maintenance of the fire alarm system, certificates of servicing and records that also confirmed quarterly checks on emergency lighting and on fire extinguishers. Fire doors were well-maintained throughout the centre, and were found to provide the required level of protection. However, inspectors identified that the provider had not identified the potential fire safety risks associated with the lack of fire stopping and detection as described under Regulation 28: Fire precautions.

There were arrangements in place to maintain the fabric of the designated centre, and an ongoing decoration programme was observed by the inspectors. Some areas of the centre were in need of upgrade as described under Regulation 17: Premises.

Surveillance of health care-associated infection (HCAI) and multi-drug resistant bacteria colonisation was routinely undertaken and recorded. Documentation reviewed identified some examples of antimicrobial stewardship practice in order to improve antimicrobial use and combat antimicrobial resistance. During the walk around, the inspectors found that the housekeeping room was in good condition and contained clean and functioning equipment. While hand-washing facilities were available in this room, they were not maintained in a manner that supported best practice for hand-hygiene standards. Specifically, the knee-activated sink did not produce appropriately tempered water, as required for effective cleansing. Additionally, the hand towel dispenser in this room was not functioning correctly to allow hands-free use. This was a similar finding with many of the hand towel dispensers. This deficit compromises the integrity of the hand-washing process, as users must make physical contact with the dispenser after washing their hands, posing a risk of re-contaminating clean hands.

Although alcohol-hand gel dispensers were in place along the corridors, they were not available at the point of care in resident bedrooms. There was a mix of hand-wash sinks, compliant and non-compliant with HBN 00-10 Part C Sanitary Assemblies. Additionally, many of the waste bins in place were not pedal-operated and were not fitted with lids, requiring manual contact with the waste to push down. This poses a risk of cross-contamination for both staff and residents.

The centre provided a full laundry service for residents. Residents whom the inspectors spoke with were happy with the laundry service. Laundry staff demonstrated good knowledge of laundry processes, specifically regarding the correct washing, and disinfection temperatures and the segregation of linen types. The laundry room's small footprint for the volume of laundry processing made the functional separation of clean and dirty phases difficult, creating a risk of cross-contamination between soiled and processed linens. There was no flat surface within the laundry to allow for sorting out clean laundry.

There were clean and tidy sluice rooms available for the reprocessing of bedpans, urinals, and commodes. However, there were some items inappropriate stored in these rooms. For example; vases, and resident washbowls were stored in this facility, which increased the risk of cross infection. The lids on sharps boxes located in the Dun a Ri sluice room were not secure. These practice did not protect staff from the risk of sharps-related injuries or healthcare-associated infections.

There were dedicated nurses' rooms for the storage and preparation of medications, clean and sterile supplies such as needles, syringes, and dressings. Sharps boxes were seen with a temporary closure mechanism in place and secured on the wall. However, single-use dressings were seen open. Once the manufacturer's seal is broken, the dressing is no longer sterile and can become a vehicle for infection. The flooring in the Dun a Ri Unit nurses' room was observed to be damaged and worn. This prevents effective cleaning and creates an environment where bacteria can grow.

The centre had arrangements in place to ensure that visiting did not compromise residents' rights and was not restrictive. Residents were able to meet with visitors in private or in the communal spaces throughout the centre.

Staff were observed to apply basic IPC measures known as standard precautions to minimise risk to residents, visitors, and their co-workers. The registered provider had substituted traditional unprotected sharps/ needles with a safer sharps devices that incorporate features or a mechanism to prevent or minimise the risk of accidental injury. Notwithstanding some of the good practices in the infection control, there were some areas that needed improvement. For example, there were opened toiletries that were not labelled for a specific resident. Shared toiletries create a risk of cross-infection between residents.

Regulation 11: Visits

Visits were seen to take place in line with visiting guidelines. Visitors were seen attending the centre throughout the inspection. Discussions with residents and visitors confirmed that they were satisfied with the arrangements that were in place.

Judgment: Compliant

Regulation 17: Premises

The registered provider provided premises which were appropriate to the number and needs of the residents living there. Outdoor space was independently accessible and safe for all residents living in the centre. However, some areas required action to be fully compliant with Schedule 6 requirements, for example:

- While the premises were generally well-maintained, several surfaces, finishes, and furnishings were seen as damaged, compromising their ability to be cleaned effectively. For example; flooring in the Duna Ri Unit nurses' room was observed to be damaged and worn. This prevents effective cleaning and creates an environment where bacteria can grow.
- While hand-wash sinks were available, they were not all compliant with HBN 00-10 standards for sanitary ware to enable staff to complete effective hand hygiene.
- The knee-activated hand wash sink in the housekeeping room failed to provide water at an adequate temperature to facilitate effective hand hygiene.
- Hand towel dispensers within the nursing home were not functioning correctly to allow hands-free use.
- The laundry room's small footprint for the volume of laundry processing made the functional separation of clean and dirty phases difficult, creating a risk of cross-contamination between soiled and processed linens.
- There was no flat surface within the laundry to allow for sorting out clean laundry.
- Storage of resident items, such as continence wear were stored outside in a non-insulated shed. This poses a risk to the integrity and hygiene of the supplies stored in here.
- Inspectors found exposed wiring in the ceiling of the lift.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy in place that included the required information as per Schedule 5 of the regulations. There was also a plan in place for responding to a major incident in the centre.

Incident reports were recorded and communicated to the person in charge and the provider. Incidents were reviewed, and where improvements were identified these were communicated to the relevant staff, and the relevant actions implemented.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27; infection control and the National Standards for infection prevention and control in community services (2018), however further action is required to be fully compliant. This was evidenced by:

- Sharps box seen with lid not in place. If a bin is knocked over or dropped, an open lid allows contaminated needles to spill out, creating an immediate needle-stick injury risk for staff and residents.
- Toiletries seen around the centre were not labelled for a specific resident. Shared toiletries, create a risk of cross-infection between residents.
- Resident washbasins and vases were inappropriately stored in the sluice room, creating a cross-contamination risk.
- Single-use wound dressings and solutions were seen open and partially used. This may impact the sterility and efficacy of these products.
- Alcohol hand-gel dispensers were in place along the corridors, but were not available at the point of care in resident bedrooms.
- Waste bins were not pedal-operated and were not fitted with lids, requiring manual contact with the waste to push down. This poses a risk of cross-contamination for both staff and residents.
- Increased oversight is required regarding the management of disinfection processes. Inconsistent chemical dilution rates pose a dual risk: under-concentration leads to ineffective decontamination of the environment, while over-concentration presents a chemical hazard to residents and staff.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were arrangements in place to protect residents in the event of fire, which included the maintenance of fire systems, and regular review of fire precautions. However, the inspectors found a number of risks that compromised fire safety. For Example:

- Two storage sheds did not have fire detection installed.
- The ceilings in two bedrooms on the ground floor had been penetrated due to the refitting of the infrastructure to hang protective curtains. These areas had not been fire stopped and posed a fire safety risk. The provider later confirmed that these areas had been filled in. Inspectors reviewed these ceilings and found that the hole had been covered, but could not confirm the material used to fill these holes was fire retardant.

- There was an exposed ceiling panel in the smoking room.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Comprehensive assessments were completed for residents on or before admission to the centre. Care plans based on assessments were completed no later than 48 hours after the resident's admission to the centre and reviewed at intervals not exceeding four months. Overall, the standard of care planning was good, and described person centred, and evidenced based interventions to meet the assessed needs of residents.

Judgment: Compliant

Regulation 6: Health care

Records showed that residents had access to medical treatment, and expertise in line with their assessed needs, which included access to a range of health, and social care specialists.

Judgment: Compliant

Regulation 8: Protection

The provider had robust systems in place to ensure residents were protected from abuse. These included safeguarding training and updates for all staff working in the centre. In addition, any allegations or incidents of abuse were recorded and investigated by the person in charge.

Records showed that all staff were up-to-date with their safeguarding training. Staff who spoke with the inspectors were able to give a good account of the types of abuse they needed to be alert for and what to do if they witnessed such an incident or a resident raised a concern to them. Staff said that they were able to talk with the nurses or the person in charge if they had any concerns.

Records showed that one recent incident had been reported, investigated and followed up in line with the centre's safeguarding policy and procedures. The provider had identified a need for additional training for some staff, and this had been completed at the time of the inspection.

The provider was not acting as a pension agent for any residents at the time of the inspection.

Judgment: Compliant

Regulation 9: Residents' rights

There were arrangements in place for residents to pursue their interests on an individual basis, or to participate in group activities in accordance with their interests, and capacities. There was a schedule of activities in place which was available for residents to attend seven days a week. Residents also had good access to a range of media which included newspapers, television, and radios.

Resident meetings were held on a regular basis and meeting records confirmed that there was on-going consultation between the staff, and residents regarding the quality of the service provided. Residents also had access to an independent advocacy service.

Judgment: 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	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Esker Lodge Nursing Home OSV-0000135

Inspection ID: MON-0048203

Date of inspection: 24/04/2026

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Summary information about residents' life history to guide staff in providing person-centred care has now been removed from resident bedrooms – complete.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: We have revised all our meeting minutes' templates to include a more detailed description of all risks in our clinical, operational governance and management and our departmental meetings in addition to our health and safety meeting minutes. We have also updated our walkaround report which is a regular visual inspection of the environment to ensure risks are identified and managed as far as is practicable - complete.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The Dun A Ri staff nurse station flooring will be replaced on 31st August 2026.	

Additional flooring repairs identified in an audit post-inspection have been added to the planned maintenance capital programme.
• A new clinical hand wash sink for the Dun A Ri staff nurse station (HBN 00-10 compliant) is on order and due for installation on 21st August 2026. Additional sinks required will be added to the planned maintenance capital programme.
• Additional checks on the housekeeping room sink post inspection have not indicated any further issues with water temperatures. Routine water temperatures be monitored and are within accepted ranges. The water temperature will continue to be monitored on a weekly basis – complete and ongoing.
• A full audit of hand towel dispensers was completed on the 3rd July and additional hands-free dispensers have been installed – complete.
• The laundry room has been reconfigured to maximise space available, to include lowering of the laundry rail, removal of excess equipment, introduction of new wheeled laundry bins and a new dedicated work bench has been sourced and installation is scheduled for 31st July 2026.
• All continence products and resident supplies have been relocated from the external store to an appropriate internal store. Fortnightly stock & storage inspections are being completed by the Housekeeping Team Leader to confirm adherence by staff.
• The certified lift maintenance contractor attended on site on 24/04/2026 and 25/04/2026 and the exposed wiring is now resolved. Service documentation has been retained on file in relation to the work completed. Ongoing servicing of the lift is scheduled on a quarterly basis – complete and ongoing.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• All staff have been reminded of the correct assembly and use of sharps boxes and management of sharps to include:
o Dedicated staff safety huddles took place over 7 days post inspection - complete
o A new Standard operating procedure was developed and is displayed beside sharps containers - complete
o All staff completed Sharps Safety training online - complete
o Sharps injury prevention has been added as a standing agenda item to the regular Health and Safety meetings - ongoing
o Monthly spot check audits have been introduced to monitor this area - ongoing.
• All toiletries are now labelled for individual resident use and are being removed from communal bathrooms when not in use – complete and ongoing.
• Washbasins and vases have been removed from the sluice rooms. Washbasins are now labelled for individual resident use and stored in their bedrooms/ ensuites. Additional washbasins have been ordered and are due for delivery on 14th August. A Standard Operating Procedure (SOP) has been developed and implemented outlining the correct

use, cleaning, disinfection and storage of care basins and this was reinforced with all staff over a 15 day period at clinical handovers for day and night staff – complete and ongoing.
• All opened single use items were discarded immediately. Staff have been reminded through safety huddles that they are not to open large packages and reuse spare wound dressings or other items labelled as single-use only. This information has also been included in the induction programme for new staff – complete and ongoing.
• Individual alcohol gel toggle bottles have been provided to all direct care staff which they wear on their person – complete.
• Waste bins were replaced with health care approved pedal operated bins with lids where required - completed 21st May 2026.
• A review of disinfectant use was conducted post-inspection. The Standard Operating Procedure was updated, and staff training and competency assessments were conducted with individual staff. New dedicated yellow containers have been procured and designated solely for the preparation of chlorine solutions to reduce error. Weekly monitoring of dilution accuracy has been implemented as a temporary measure to audit this practice until no longer required – completed 21 May 2026 and ongoing.

Regulation 28: Fire precautions	Substantially Compliant

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

• The installation of fire detection devices within the two external storage sheds has been scheduled with the approved contractor and is due to be completed on 31 July 2026. Additional fire-proofing of both sheds was also completed.
• The ceiling penetrations identified in the two ground floor bedrooms were sealed immediately on the day of inspection using an approved fire-stopping product. The Provider has retained the manufacturer's technical data sheet and product certification within the fire safety records to verify compliance – complete. Ongoing spot-check audits will be completed to identify any further risks presenting.
• The ceiling panel in the smoking room was replaced immediately – complete.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/08/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	24/04/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Substantially Compliant	Yellow	24/04/2026

	effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	14/08/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/07/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	24/04/2026