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

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| Name of designated centre: | St Gabriel's Nursing Home |
| Name of provider: | SGNH Limited |
| Address of centre: | Glenayle Road, Edenmore, Dublin 5 |
| Type of inspection: | Unannounced |
| Date of inspection: | 22 April 2026 |
| Centre ID: | OSV-0000174 |
| Fieldwork ID: | MON-0050211 |

## About the designated centre

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

St. Gabriel's Nursing Home is located in North Dublin and provides residential and respite care for male and female residents over the age of 18 years. The premises is a 68-bedded facility expanding over two floors consisting of 60 single and four double rooms. The ground floor is called the Jasmine suite and consists of 28 rooms. There are 30 residents in total on this floor all of varying dependency. The top floor is called the Lavender suite and consists of 36 rooms. There are 38 residents all from varying dependency. The designated centre has a reception area with seating space and a sun room, which looks onto one of multiple garden courtyards. Multiple communal living rooms are available for residents to relax, socialise, watch TV, read or participate in activities. The building also features a hairdressing salon, a chapel, large dining rooms, and on-site kitchen and laundry facilities.

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

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| Number of residents on the date of inspection: | 68 |

## 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 |
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| Wednesday 22 April 2026 | 08:00hrs to 16:30hrs | Aislinn Kenny | Lead |
| Wednesday 22 April 2026 | 08:00hrs to 16:30hrs | Frank Barrett | Support |

## What residents told us and what inspectors observed

This was an unannounced inspection carried out by two inspectors over one day. The purpose of the inspection was to monitor ongoing compliance with the regulations and standards and to follow up on the registered provider's compliance plan from the previous inspection. The majority of residents spoken with told the inspectors that they were happy and content living in the centre, and two residents said that at times they were waiting for their call-bells to be answered. The residents had high praise for the staff working there describing them as 'wonderful' and 'marvellous'. There was a friendly and welcoming atmosphere in the centre and inspectors observed that staff and resident interactions were kind and friendly. Staff and residents appeared to know each other well and were observed chatting throughout the day. Visitors spoken with told inspectors they were happy with the centre and the care provided to their loved ones.

The centre provides accommodation for a maximum of 68 residents and is laid out across two floors with access by stairs, lift and a chair lift. Residents had access to a number of communal day spaces on both the ground and first floor such as a chapel, conservatory activity room and sitting rooms; the main dining room was located on the ground floor. Residents' accommodation was provided in shared and single bedrooms located on both floors. On arrival to the centre the inspectors walked around the centre and observed the morning routine for residents. There was a calm and relaxed atmosphere observed in all units. Inspectors found that while the cleanliness of the centre had overall improved, the wash-up area remained in a poor state of cleanliness. The inspectors observed that the wash-up area was unclean with dirt visible in areas, which was a repeat finding from the last inspection. Staff spoken with told inspectors that a deep-clean had been carried out following the last inspection.

Inspectors observed that fire safety concerns had mostly been addressed in line with the registered provider's compliance plan. However, on this inspection, inspectors also found other aspects of the premises and significant fire safety concerns that had not been identified by the provider's own systems and also required attention as discussed further in the report.The premises was large and mostly well-maintained, however further works were required as damage was noted to floors, walls and ceilings in various parts of the centre which required attention. A bath for resident use was not in working order, and there were signs of a leak in the bathroom ceiling.

Residents were observed in various communal areas throughout the day. In the morning, residents were observed saying the rosary in the chapel and later in the afternoon some residents were seen enjoying crafts in the activities room. Other residents were watching television in the smaller day rooms or hosting visitors in the

courtyard areas or conservatory areas. Most residents' bedrooms were observed to be spacious and an improved level of cleanliness was observed in these areas.

Meals and refreshments were served throughout the day and the inspectors observed the dining experience for residents. Most residents chose to eat together in the day rooms or the dining room on the ground floor. Staff serving the meals knew the residents well and their likes and dislikes. Meals were nicely presented and appeared wholesome and nutritious. Residents confirmed that the food was tasty and they had a choice at mealtimes. Breaches of integrity in some serving areas were observed in the main dining areas and in the ground floor; in addition the trolleys used to transport trays of food to residents in their bedrooms were dusty and visibly unclean. This was brought to the attention of the staff and person in charge on the day.

Residents had unrestricted access to a secure courtyard and garden area. This area was generally well-maintained, with decking, flower beds and pathways. There was also outdoor seating available for residents to use. One resident told inspectors they would like to be able to walk the perimeter of the centre to get more fresh air.

The next two sections of this report set out the findings of this inspection in relation to the governance and management arrangements in place in the designated centre, and how these arrangements impacted on the quality and safety of the services being delivered.

## Capacity and capability

Overall, the inspectors found that while residents' care was of a good standard, the oversight and management of premises, infection prevention and control (IPC) and fire precautions was not sufficient to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored.

Following the last inspection of July 2025, a cautionary meeting was held with the registered provider, where the provider gave assurances that the inspection's findings were addressed, swift action had been taken in respect of increased oversight of cleaning and that the wash-up area on the ground floor was deep-cleaned. The inspectors found that whilst the provider had completed the majority of the actions committed to in their compliance plan from the previous inspection in relation to fire safety and premises there was no improvement seen in the cleanliness of the wash-up area, despite assurances provided by the provider in their compliance plan. This was the third inspection where a lack of cleanliness was found and the provider had failed to take appropriate action to address this. Inspectors also found on this inspection that the registered provider was operating outside of their registered statement of purpose. This and further findings are discussed under Regulation 23: Governance and management.

The registered provider of St Gabriel's Nursing Home is SGNH Limited. The centre is part of the wider Beechfield Care group who operate several centres nationally. The person in charge reported to a senior management team including a company director and was supported in their role by a dedicated staff team consisting of clinical nurse managers, staff nurses and healthcare assistants, housekeeping staff, activities co-ordinators, catering and administration staff. Maintenance support was provided on-site and supplemented by a contracted provider. The provider had recruited an additional clinical nurse manager following the last inspection and the positive impact of this was seen with improved auditing systems, although improvement was also required in this area. A physiotherapist was employed in the centre on a full-time basis as per the registered statement of purpose however, inspectors found that the physiotherapist was being shared with another centre since January 2026. This meant that residents of St Gabriel's Nursing Home did not benefit from a physiotherapist on a full-time basis, and the services provided were not in line with the statement of purpose.

The inspectors reviewed a sample of contracts for the provision of services to residents. Whilst there was a contract in place for residents, the inspectors found that some contracts did not set out all criteria required under the regulations. This finding is discussed further under Regulation 24: Contract for the provision of services.

Clinical governance meetings were seen to take place with areas of concern discussed which included care planning, residents' care, notifiable incidents. A monthly operations meeting took place to discuss premises and housekeeping. While a schedule of audits was in place and key indicators of quality of care were collected some improvement was required to ensure the information being captured was appropriately actioned. The auditing and oversight management systems in place required to be strengthened, as detailed in Regulation 23: Governance and management.

There was a low level of incidents and complaints recorded on the registered provider's incident management system. From the sample of incidents reviewed, the Chief Inspector was notified appropriately. Complaints were seen to be responded to in line with the registered provider's policy. However, the registered provider did not ensure that a report on the complaints received, including reviews conducted, was included in the annual review.

Staff were provided with training appropriate to their roles. The registered provider ensured that all staff were up-to-date with mandatory trainings. Inspectors found that most trainings were provided online including safeguarding training, responsive behaviour training and infection control. Fire safety and manual handling trainings were provided in person. The inspectors were informed that face-to-face training in IPC was provided by the Clinical Nurse Manager (CNM).

The management and oversight of fire safety required additional review. A fire safety risk assessment (FSRA) was carried out in 2024 by a third party consultant, which identified some but not all of the high risk concerns identified on this inspection. Since the last inspection the provider had completed an upgrade of the

kitchen compartments, fire shutters fitted to lifts, and additional signage posted to assist with fire action. The building was a long standing structure, with additions over time. Some of these additions changed the nature of fire safety and impacted on the evacuation of the centre (inadequate refuge spaces, excessive travel distances and the use of thoroughfare spaces) however, no design drawings or certification could be identified to outline these. The FSRA completed did not review the fire certification of the building, and this element was discussed with the provider at the end of the inspection. The provider committed to reviewing the designed fire certificates and ensuring the use of the building complied with that cert. A copy of fire certificates and associated documentation were requested to be sent to the Chief inspector following the inspection.

The fire safety policy placed requirements for the ongoing auditing and checking of fire safety systems, including weekly fire door checks. These checks indicated that the fire doors were operating correctly, however, this inspection found multiple issues with fire doors throughout which were not reflected in these audits. Fire safety is discussed in more detail under Regulation 28: Fire Precautions in the Quality and Safety section, and the management and oversight of fire safety is discussed under Regulation 23: Governance and Management.

## Regulation 16: Training and staff development

Supervision of staff required improvement to ensure that cleaning of the wash-up area was being carried out appropriately.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The registered provider did not ensure that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- A physiotherapist employed by the centre on a whole time basis was not working in the centre on a whole time basis. Since January 2026 the staff member had been working in another centre on a part-time basis. This was not in line with the registered providers' statement of purpose for the centre.
- Cleaning products in use by the centre in the wash-up area required review to ensure they were effective for the type of equipment they were being used for.

While the registered provider had some assurance systems in place regarding the quality and safety of the service, there were repeated failings in respect of

cleanliness and a number of areas were identified that required action. This was evidenced by:

- Despite previous assurances given by the provider that the cleanliness of the kitchen wash-up area would be addressed this was found not to be the case on this inspection and this was a repeat finding for the third inspection. An action plan was submitted by the provider to the Chief inspector following the inspection addressing these repeat findings.
- Further review of fire safety risk was required to ensure that the building and its operation are in line with statutory fire certificate designs and that residents are protected from excessive risk of fires. This included: ensuring that appropriate travel distances are maintained, appropriate disabled refuge space is available for each escape route, and that escape routes are not used as operational space such as day rooms.
- The provider's internal fire door auditing system was inadequate. A thorough fire door audit was required in order to set out the status of all fire doors and put in place a remedial action works list.
  Inspectors reviewed the previous fire safety risk assessment which was dated 2024 and noted that some issues identified had not been implemented.
- Call-bell audits were taking place in the centre with delayed response times noted in February, March and April. Inspectors found that the action plan for these audits was generic and similar for all and did not show evidence of improvement despite the action plan being in place.
- The oversight of storage arrangements required significant review to ensure that practice was not impacting on infection prevention and control standards, general maintenance and housekeeping standards, and impacting on fire safety
- From a review of residents' meeting minutes for February and March 2026, inspectors found that the action plan was blank with no follow up details recorded. This meant that there was no meaningful action taken on foot of concerns raised by the residents.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of five residents' contracts for the provision of services and found that four of the five contracts did not state the occupancy level of the residents' bedroom.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

Incidents and reports as set out in Schedule 4 of the regulations, were notified to the office of the Chief Inspector within the required time frames.

Judgment: Compliant

## Regulation 34: Complaints procedure

While the low level of complaints received by the complaints officer were seen to be responded to in line with policy, the registered provider did not ensure that as part of the designated centre's annual review, a general report was provided on the level of engagement of independent advocacy services with residents, and complaints received, including reviews conducted.

Judgment: Substantially compliant

## Quality and safety

Overall, residents living in St Gabriel's nursing home were supported to live a good quality of life. Residents' rights were being promoted by
a dedicated staff team who knew and understood the residents well. While the registered provider had taken some action in line with their compliance plan from the previous inspection, further improvements were required to comply with fire safety, premises and infection control regulations as discussed further in the report.

The inspectors viewed a sample of residents' notes and care plans. There had been improvements in the standard of care planning, but further improvements were required to ensure that they were updated to guide safe and effective care. Details are presented under Regulation 5: Individual assessment and care plan.

In respect of the use of premises, the inspectors found that a number of areas were were not listed on the registered floor plans including some spaces used for storage. Other storage spaces were found to be overfilled resulting in some of the materials being stored on the floor. There was a large bright chapel available for residents to use as well as numerous day spaces, however, some of these day spaces were also through ways from other spaces which required review. This is discussed further under Regulation 17: Premises.

The centre was equipped with a serviced fire detection and alarm system, which was installed to a category L1 status, which should ensure detection and audible alarm in all areas of the centre. However, inspectors found that not all spaces had detection in place. Fire extinguishers were placed at strategic locations throughout

the centre which were maintained and visible. The evacuation routes were generally kept clear however, the need to travel through some day rooms as an alternative escape route from other spaces could present obstructions to escape. Escape routes from the main ground floor dining included the use of an exit door which was not wide enough to use by residents with mobility aids. There was also a step down outside this door which required remediation.

Emergency lighting directional signage also required review as outlined further in the report under the relevant regulation. Records of fire drills did not reflect that staff had tested the evacuation of the largest compartments under low staffing numbers. This and other fire safety findings are detailed under Regulation 28: Fire Precautions.

While there were some improvements seen in the management of infection prevention control and cleanliness of the centre in areas used by residents. On this inspection the management of and efficacy of cleaning in the kitchen wash-up area had not been addressed and remained a finding as outlined under Regulation 27: Infection prevention and control.

Action had been taken to accurately update the restrictive practices register since the previous inspection. There was a policy in place to guide staff on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. Staff had online training in managing behaviour that is challenging.

Residents' rights were upheld in the centre and all interactions observed during the day of inspection were person-centred and courteous. Residents had access to meaningful activities. The weekly activity schedule reflected a seven day schedule, it was on display for residents to view and residents were involved in person-centred activities throughout the day of inspection.

## Regulation 17: Premises

The registered provider had not fully ensured that the premises was in line with the Statement of Purpose and the floor plans for which it is registered. For example:

- The registration floor plans and statement of purpose required review to ensure all areas of the centre used for the running of the centre were reflected. This included two rooms used for storage which were not on the plans and a number of doors on corridors which were not indicated on the registration drawings.

Improvements were required from the registered provider, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Storage practice required review as some storage spaces were overfilled with materials stored on the floors. This would make cleaning of the store rooms and access to certain materials more difficult.
- Areas of flooring in some parts of the centre required repair. Some of the joints in the flooring material were separating resulting in cracking, and other flooring areas were damaged due to wear.
- Ceilings in some locations required maintenance attention, including a kitchenette near the main kitchen and a bathroom where evidence of a previous leak was still visible on the ceiling.
- A bath at the centre was not in working order. The tiles on the walls of this bathroom were also damaged and required remedial works.

Judgment: Substantially compliant

## Regulation 27: Infection control

The provider did not meet the regulatory requirements and the *National Standards for infection prevention and control in community services (2018)*. Poor practice was observed in the area of infection control. For example:

- The kitchen wash-up area was unclean, which is a recurrent finding. Inspectors observed paint flaking off the ceiling above the wash-up areas, the trolleys used to deliver residents' meals were dusty and dirty. Tea trolleys were not cleaned to an appropriate standard with dirt observed in the grooves of the handles. A build up of lime scale was observed on stainless steel cabinets. Inspectors were told by staff the cleaning products they were using were not effective enough to address this.
- Screens covering the windows in the wash-up area were not sufficiently cleaned and some required maintenance.
- There were breaches of the integrity in the wooden cabinet used to serve the porridge in the main dining room and this was also observed in the individual kitchenettes in the day rooms on the ground and first floors, which did not ensure they could be effectively cleaned.
- There was a significant build-up of dirt in the floor tiles between the kitchen wash-up area and the dining room entrance.
- Milk jugs used to serve residents had a build up of residue inside them and required replacing.
- A door to the medical room in the lavender unit was dirty and required cleaning

An urgent action was issued on this and the provider's response did provide the assurance required.

Judgment: Not compliant

## Regulation 28: Fire precautions

The registered provider did not provide adequate means of escape, including emergency lighting, for example:

- An exit door from an escape corridor near the kitchen was narrow and had a step outside the door. This was an escape route from the resident dining room area, which posed the risk that the evacuation of residents with higher mobility needs would be challenging in the event of fire.
- Appropriate disabled refuge space was not available at all exit routes. This was particularly evident at one stairs which was near resident bedrooms as the stairs door opened above the top of the straight flight of stairs. This would impact on residents in the area that were non-ambulant and required the refuge space in the event of a fire.
- Emergency lighting including directional signage required review to ensure that all escape routes including external escape routes would be illuminated in the event of a fire and subsequent power loss. Directional signage was not in place on a first floor dining room, and a ground floor emergency exit door did not appear to have an exit sign.

Action was required by the registered provider, to ensure by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of a fire. For example:

- While fire drills were being conducted at the centre regularly, the drills did not reflect the evacuation of the entire compartment. Some compartments had up to 11 bedrooms within them. Some areas of the centre required longer travel distances to reach an exit or compartment line. This would place additional pressure on staff in an evacuation scenario and required training to ensure the times taken were as low as possible.
- The floor plans posted on walls to assist in evacuation did not reflect the compartment lines to effectively support the progressive horizontal evacuation system used at the centre.

The registered provider did not make adequate arrangements for detecting or containing fires. For example:

- Fire detection was not available in all areas, including in storage spaces and concealed spaces under stairs.
- Services passing through compartment lines were not sealed, thus providing a route for fire smoke and fumes to penetrate these compartment lines. This was noted in high fire-risk rooms such as the communications room, and electrical switch rooms. The areas at the rear of the kitchen where the main electrical and mechanical services entered the building from the boiler room required review to ensure appropriate compartmentation was in place.
- The containment measures in place around fire doors were not adequate. Fire doors were noted with non fire-rated ironmongery including hinges and

handles. One treatment room door had a ventilation grille fitted which may negate its fire rating. Some doors had damage to the edges, large gaps around the sides and damaged smoke and fire seals.
- A space used as storage under a stairs was not provided with any fire-rated construction to protect the escape route. This storage was removed on the day of the inspection, however, the construction of this room requires review to ensure it provides a fire-rated separation to the stairs.
- Electrical and communications equipment fitted within a treatment room did not appear to be provided with appropriate fire-rated construction to contain fires and smoke.
- The fire resistance of the enclosure which surrounded the nurses station required review to ensure the materials including glass and wood structure provided protection to the escape route.

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

From a sample reviewed, residents' care plans were mostly up-to-date and person-centred however, improvement was required for example;

- The personal evacuation plan in place for a resident in the event of a fire contained information contradictory to their mobility care plan. This was a repeat finding from the previous inspection and posed a risk that staff would not know how to transfer a resident in the event of evacuation.

Judgment: Substantially compliant

## Regulation 7: Managing behaviour that is challenging

The designated centre's policy was available for review. There were appropriate and detailed care plans in place which reflected the residents' individual needs, known triggers and known de-escalation techniques.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents’ rights and choice were promoted and respected in this centre. There was a focus on social interaction led by staff, and residents had daily opportunities to

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| participate in group or individual activities. Access to daily newspapers, television and radio was available. Details of advocacy groups was on display in the centre. |
| 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 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 27: Infection control | Not compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 7: Managing behaviour that is challenging | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for St Gabriel's Nursing Home OSV-0000174

## Inspection ID: MON-0050211

## Date of inspection: 22/04/2026

**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 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br><br>The Person in Charge has reviewed and strengthened supervision and oversight arrangements to ensure that all staff complete cleaning duties in the wash-up area in accordance with the homes cleaning schedules, infection prevention and control procedures, and food safety requirements. Daily and weekly cleaning schedules are in place and checked by the CNM to ensure they are being adhered to.<br>Cleaning records are currently being reviewed monthly by management, and any identified gaps in practice will be addressed through meetings and performance management processes where required. Compliance with cleaning procedures will form part of ongoing staff supervision and annual performance reviews to ensure sustained adherence to required standards. Should training needs be identified we will arrange refresher training for staff.<br>A daily kitchen inspection was carried out post inspection for a two-week period and monthly thereafter. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br><br>A review of physiotherapy resources was completed immediately following the inspection. The physiotherapist's working hours have been revised to ensure that the post is operating on a full-time basis within the designated centre, in line with the | |

Statement of Purpose. This arrangement has now been implemented since the beginning of May and is operating effectively. Ongoing monitoring will be undertaken by the Person in Charge and Registered Provider to ensure continued compliance with staffing commitments outlined in the Statement of Purpose.
Following the inspection, the kitchen wash-up area underwent a comprehensive deep clean by an external specialist cleaning contractor. The ceiling was re-painted with a suitable paint for the area. In addition, all cleaning products used within the wash-up area have been reviewed to ensure they are appropriate and effective for the equipment and surfaces being cleaned. To ensure sustained compliance, kitchen staff rosters have been revised to provide extended cover into the late evening. Specific cleaning responsibilities have been assigned to designated staff members as per the daily/weekly checklist and are required to be completed daily/weekly in accordance with revised cleaning schedules and infection prevention and control procedures. The completion of cleaning duties is monitored daily by management, with records maintained to provide assurance that cleaning standards are consistently achieved.
The Registered provider continues to progress the actions contained within the compliance plan in relation to fire safety governance and management.
A comprehensive fire door audit has been completed by an external competent fire safety company, and the centre is now in receipt of the full repor. The findings of the audit are currently being reviewed, and quotations have been requested from suppliers for the identified remedial works. Once costings have been received and contractors appointed, a timeframe for completion of works will be agreed and implemented.
The 2026 Fire Risk Assessment has been completed. A time-bound action plan has been developed to address the recommendations arising from the assessment, with actions being monitored through the centre's governance and oversight arrangements.
An external fire safety company has attended the centre to undertake an assessment of fire stopping, fireproofing and fire compartment requirements throughout the centre. The provider is currently awaiting further investigation by the competent fire engineers, once this work is fully complete a report will be issued and a time-bound action plan will be completed and implemented to ensure fire safety regulation compliance.
The centre is awaiting a report by a external fire safety company regarding the full review of fire refuge spaces within the designated centre. This review will assess the suitability, signage and operational effectiveness of all refuge areas and will identify any recommendations for improvement. The provider will implement any recommendations from this report within agreed timeframes.
The registered provider remains committed to ensuring that all fire safety arrangements within the designated centre are fully aligned with statutory requirements and best practice and will continue to progress all identified actions to completion through the centres governance and management structure
The effectiveness of the call-bell monitoring system has been reviewed. Audit processes and action plans has been strengthened to ensure that delayed response times are fully investigated, root causes identified, and targeted actions implemented. Trends are being monitored through the quality assurance system to ensure measurable and sustained improvement. This is being monitored daily by the nurses and monthly by CNM's.
Storage arrangements throughout the centre has been reviewed to ensure compliance with infection prevention and control requirements, housekeeping standards, maintenance requirements, and fire safety regulations. A complete review of items being stored was carried out and unnecessary items removed from the premises. Appropriate storage areas be designated and monitored through routine environmental audits. This

will be carried out monthly by the CNM. An area being used for storage and deemed inappropriate and not in the floor plan was removed.
The provider has strengthened oversight of resident consultation processes. Resident meeting templates have been revised to ensure that concerns, suggestions, and requests raised by residents are clearly documented, discussed and outcome assigned to a responsible person and followed through to completion. Outcomes and actions taken will be communicated to residents and reviewed as part of the home's quality assurance programme.

| Regulation 24: Contract for the provision of services | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

The Registered Provider has reviewed the contracts for the provision of services for all residents within the designated centre to ensure that they contain all information required under the regulations.
The centre's contract template has been revised to include a specific section detailing bedroom occupancy status, ensuring that this information is clearly documented for all future residents.

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

The Registered Provider will ensure that the designated centre's annual review includes a comprehensive report on the complaints process and the engagement of independent advocacy services, in accordance with regulatory requirements.
Following the inspection, the annual review template has been revised to include a dedicated section outlining the number and nature of complaints received, the outcomes of complaints investigations, any reviews undertaken, trends identified, lessons learned, and actions implemented to improve service delivery. This was carried out immediately after the inspection.
The revised annual review process will also include a summary of residents' access to and engagement with independent advocacy services, including the level of advocacy involvement within the centre and any themes or issues identified through advocacy engagement.

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| Regulation 17: Premises | Substantially Compliant |

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

The Registered Provider will ensure that the premises are maintained in accordance with the Statement of Purpose, registration requirements, and Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations.
A review of the centre's floor plans and Statement of Purpose has been undertaken to ensure that all areas used in the operation of the designated centre are accurately reflected. Revised floor plans have been commissioned to reflect the removal of an unsuitable storage room and include the correct number of doors in the centre. The Statement of Purpose will be updated, where required, to accurately reflect the premises
A comprehensive review of storage arrangements has been completed. Storage rooms have been reorganised to ensure safe and appropriate storage of equipment and supplies, with items removed from floor level to facilitate effective cleaning, improve accessibility, and maintain housekeeping, infection prevention and control, and fire safety standards. Ongoing monthly environmental audits will monitor compliance with storage requirements.
An independent contractor has been sourced to review the works required for the flooring. A plan will be devised once the report received.
Maintenance works were undertaken to address ceiling defects identified during the inspection. Areas affected by previous water ingress have been completed and monitored to ensure that the integrity of the ceiling surfaces is maintained.
A new bath will be installed in the centre, and tiles will be repaired and replaced.

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| Regulation 27: Infection control | Not Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:

The Registered Provider has taken immediate action to address the infection prevention and control concerns identified during the inspection and is committed to ensuring compliance with Regulation 27 and the National Standards for Infection Prevention and Control in Community Services.
Following the inspection and urgent action response, The ceiling in the wash up area was cleaned and painted with a suitable paint and the kitchen and wash-up area underwent a comprehensive deep clean by an external specialist cleaning contractor. All food service equipment, surfaces, storage areas, trolleys, and ancillary areas were thoroughly cleaned. A review of the cleaning products used within the wash-up area was also undertaken and appropriate products have been sourced to ensure effective cleaning and descaling of equipment and surfaces. A daily kitchen inspection was carried out post

inspection for a two-week period and monthly thereafter.
Kitchen staff rosters have been revised to provide extended cover into the late evening to facilitate the completion of all required cleaning tasks. Specific daily / weekly cleaning responsibilities have been drawn up and detailed cleaning schedules have been implemented. Cleaning activities are monitored daily by supervisory staff, with records maintained to provide assurance that cleaning standards are consistently achieved.
All meal delivery trolleys and tea trolleys have been thoroughly cleaned and incorporated into the revised cleaning schedules. Enhanced oversight arrangements, including routine supervisory checks and environmental hygiene audits, have been implemented to ensure that equipment remains visibly clean and maintained to an appropriate standard.
The window screens within the wash-up area have been cleaned and those requiring maintenance were repaired. These are now included within the weekly cleaning schedule and staff reminded to report any repairs needed to maintenance.
A review of fixtures and fittings identified areas where damaged surfaces could impact effective cleaning. The wooden cabinets used for food service in the dining room and day room kitchenettes have been assessed and remedial works are being carried out to replace damaged surfaces, we also ordered glass tops to ensure they can be effectively cleaned and maintained.
The flooring between the wash-up area and dining room entrance has been deep cleaned and incorporated into enhanced cleaning schedules. The condition of the flooring will be monitored through regular environmental audits and addressed through the maintenance programme where required.
All milk jugs used for resident service were reviewed immediately following the inspection. Items showing signs of wear, staining, or residue build-up were removed from use and replaced. A system has been implemented to routinely inspect food service equipment to ensure it remains clean and fit for purpose.
The door to the medical room in the Lavender Unit was cleaned immediately following the inspection and has been included within routine cleaning schedules and environmental audit

| Regulation 28: Fire precautions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• A full review of the exit door near the kitchen is being carried out by an independent fire contractor. In the interim staff have been informed to use alternative fire exits within the vicinity.
• A full review of all refuge spaces within the home is being carried out by a competent fire person.
• New Emergency lightening and directional signage has been reviewed and completed by an external fire company.
• Following the inspection, all fire drills are now being completed based on full occupancy of residents in their designated compartments, to include day and night scenarios.
• Fire compartment signage has now been placed throughout the Centre to identify each separate compartment.
• A full review of fire detection was carried in the home. Following this, works will

commence on completion of fire detection in all areas, including in storage spaces and concealed spaces under stairs.
• A full review of the electrical and communication equipment is being carried out in both treatment rooms within the home.
• An independent contractor will carry out a review of fire resistance of the enclosure which surrounded the nurses station to including glass and wood structure.
• A comprehensive fire door audit has been completed by an external competent fire safety company, and the centre is now in receipt of the full report. The findings of the audit are currently being reviewed, and quotations have been requested from suppliers for the identified remedial works. Once costings have been received and contractors appointed, a timeframe for completion of works will be agreed and implemented.
• The 2026 Fire Risk Assessment has been completed. A time-bound action plan has been developed to address the recommendations arising from the assessment, with actions being monitored through the centre's governance and oversight arrangements.
• An external fire safety company has attended the centre to undertake an assessment of fire stopping, fireproofing and fire compartment requirements throughout the centre. The provider is currently awaiting further investigation by the competent fire engineers, once this work is fully complete a report will be issued and a time-bound action plan will be completed and implemented to ensure fire safety regulation compliance.
• The centre is awaiting a report by a external fire safety company regarding the full review of fire refuge spaces within the designated centre. This review will assess the suitability, signage and operational effectiveness of all refuge areas and will identify any recommendations for improvement. The provider will implement any recommendations from this report within agreed timeframes.
• The registered provider remains committed to ensuring that all fire safety arrangements within the designated centre are fully aligned with statutory requirements and best practice and will continue to progress all identified actions to completion through the centre's governance and management structure.

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| Regulation 5: Individual assessment and care plan | Substantially Compliant |

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

The Physiotherapist carries out reviews of residents in this area and should their mobility decline they are moved to a more suitable room.
A detailed manual handling and PEEP chart is kept in each room and is reviewed every 4 months or as required. Fire drills are carried out monthly and findings are discussed at daily handover and amended in manual handling and PEEPS charts.

## 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 |
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| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 01/05/2026 |
| Regulation 17(1) | The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3. | Substantially Compliant | Yellow | 31/07/2026 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Substantially Compliant | Yellow | 31/12/2026 |

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| Regulation 23(1)(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. | Not Compliant | Orange | 31/12/2026 |
| Regulation 23(1)(d) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 31/12/2026 |
| Regulation 24(1) | The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre. | Substantially Compliant | Yellow | 24/04/2026 |
| Regulation 27(a) | The registered provider shall ensure that infection | Not Compliant | Orange | 30/06/2026 |

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| | prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff. | | | |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 15/05/2026 |
| Regulation 28(1)(e) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Substantially Compliant | Yellow | 30/06/2026 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/12/2026 |
| Regulation 34(6)(b)(i) | The registered provider shall ensure that as part of the designated centre's annual review, as referred to in Part 7, a general report is | Substantially Compliant | Yellow | 15/05/2026 |

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| | provided on the level of engagement of independent advocacy services with residents. | | | |
| Regulation 34(6)(b)(ii) | The registered provider shall ensure that as part of the designated centre's annual review, as referred to in Part 7, a general report is provided on complaints received, including reviews conducted. | Substantially Compliant | Yellow | 15/05/2026 |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. | Substantially Compliant | Yellow | 15/05/2026 |