Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St 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 July 2025
Centre ID:	OSV-0000174
Fieldwork ID:	MON-0047251

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.

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
Tuesday 22 July 2025	08:40hrs to 17:40hrs	Aislinn Kenny	Lead
Tuesday 22 July 2025	08:40hrs to 17:40hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

Overall, residents living in St Gabriel's Nursing Home told inspectors they were happy with the care provided and that they were well looked after by the team of staff working there. Inspectors spoke with 12 residents and spent time in communal areas and walking around the centre observing interactions between staff and residents and saw that these interactions were calm and respectful. The centre itself was laid out to meet the needs of the residents however, inspectors found there were areas of the centre that required urgent action to ensure they were cleaned to an acceptable level. Fire safety concerns were also identified throughout the day. An urgent action was issued to the provider following the inspection in respect of the cleanliness of the centre and fire safety concerns.

On the morning of the inspection some residents were observed to be up and about sitting in various areas in the centre while others were having their morning care needs attended to by staff. During the walk around the inspectors observed areas of the centre and residents' equipment that was visibly dirty. There was poor ventilation observed in some residents' bathrooms and other rooms in the centre. The floor coverings in some residents' bedrooms were visibly unclean and the kitchen wash-up area opposite the main kitchen was visibly unclean, which was a repeat finding from the last inspection. The person in charge was responsive to issues identified during the inspection.

The inspectors met with six visitors during the inspection. Most visitors expressed a high level of satisfaction with the quality of the care provided to their relatives and friends and many stated that their interactions with the management and staff were positive. One visitor spoken with said communication with the management in the centre needed to be improved. Most visitors reported that the management team were approachable and responsive to any questions or concerns they may have. One family member said "the staff couldn`t do more" and "this place is like home from home".

Residents' bedroom accommodation was spacious and bright in many of the single en-suite rooms. However a number of improvements were required in relation to premises and maintenance throughout the centre. Inspectors observed that in two of the twin bedrooms there were no privacy curtains in place. During the walk around inspectors observed that a washing machine contained in a room off the corridor of Lavender unit was plugged into a scorched plug socket via an extension lead. An immediate action was issued to the provider to remove this from use until it was assessed by a competent person. Residents' bedrooms were lit by nightlights which were set into the wall just above ground level and were covered by a glass cover. In one resident's bedroom the glass cover had been removed and the light bulb was exposed posing a risk to the resident; an immediate action was issued to address this also.

Residents were observed taking part in activities on the ground floor throughout the day and activities included exercise class, music and singing and Mass. There was a large chapel in the centre and inspectors were informed Mass took place here three times per week. Mass was shown in the activities room on the day of the inspection. Pictures of residents and residents' artwork were placed around the corridors on the ground floor providing a welcoming atmosphere. There were large information boards in the reception area which displayed the complaints procedure, activities schedules and the names of the staff allocated to the units on the day. The reception area and conservatory were nicely decorated however, the conservatory was unclean and dust and debris was observed on windowsills and on the floor in this area. The doors to the conservatory which were fire doors were kept open however, they were not on automatic closures and would be required to be manually closed in the event of a fire alarm.

Clinical hand-washing sinks had been installed on corridors to support effective hand hygiene. These complied with current recommended specifications for clinical hand hygiene sinks. However, alcohol hand rub was not available at point of care within bedrooms as recommended in national guidelines.

Inspectors observed the residents dining experience and residents were complimentary of the food provided, which was prepared as per their preferences. Mealtimes were seen to be a sociable experience and residents were observed enjoying listening to relaxing music and chatting amongst themselves.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

Overall, this inspection found that the registered provider had failed to provide a safe and effective service that was compliant with the regulations. The provider did not ensure that appropriate systems of management were implemented to monitor the quality of care, and respond to risks that impacted on the safety and welfare of residents with respect to fire safety and infection control measures. This resulted in a deterioration in the quality and safety of the service and repeat findings of non-compliance in respect of infection prevention and control, fire safety and notifications of incidents. As a consequence of these concerns, an urgent compliance plan request was issued to the provider following this inspection. The plan submitted was accepted by the Chief Inspector.

SGNH Limited is the registered provider of St Gabriels Nursing Home which is part of the Beechfield Care Group, that has a number of nursing homes in the country. The

local management team consists of the person in charge and two clinical nurse managers (CNM's). The management team is supported by senior members of the Beechfield group, one of whom was present on the day of the inspection. Although there was a clearly defined management structure in place, as outlined in the centre's statement of purpose, there had been a recent change in senior management roles and inspectors found this had led to gaps in the oversight of fire safety as discussed further in the report.

The registered provider had audit and monitoring systems in place to oversee the service. However, the audit system was not sufficiently robust as it had failed to identify key areas for improvement and poor infection prevention and control (IPC) practices. Also, the provider had failed to nominate an IPC link nurse with the appropriate skills to support the person in charge This is discussed under Regulation 23: Governance and Management and Regulation 16: Training and staff development. The registered provider had undertaken a fire safety risk assessment (FSRA) following the last inspection. There was an action plan corresponding to this which outlined the time-frame for completion and action and the nominated people responsible. Inspectors found that some items from the FSRA remained outstanding on the action plan for more than six months and there was no evidence that these actions had been reviewed during this time period. The provider submitted an updated action plan following the inspection, as requested.

There were sufficient staff on duty on the day of the inspection to support the needs of the residents. The staff were visible within the nursing home tending to residents' needs in a respectful manner.

Staff were facilitated to attend training such as fire safety, manual handling and managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). While there were some gaps identified in these trainings the registered provider had a plan in place to address these. Although staff were facilitated to attend training relevant to infection control, some staff did not have an appropriate awareness of the procedures and processes required to demonstrate the effectiveness of the training.

Policies and procedures required by Schedule 5 of the regulations were available for review. Action was required to ensure that the risk management policy and fire safety policy were appropriately reviewed within the time frame provided and that policies in place were adequately implemented by staff.

The registered provider had a complaints procedure in place which was on display throughout the centre. A review of the small number of complaints logged found that they were resolved in an informal manner. Oversight of the management of complaints required improvement. For example, inspectors found that the content of a verbal complaint relating to the care of a resident was discussed with another family member in an effort to close the complaint and was not initially addressed with the complainant. Other findings are outlined under Regulation 34:Complaints Procedures.

A review of the incident and accident log found that a power outage in the centre had not been notified to the Chief Inspector in line with the requirements of the regulations.

Regulation 15: Staffing

On the day of this inspection there were sufficient staff on duty in the centre, to meet the assessed care needs of residents given the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Practices observed demonstrated that additional infection prevention and control training and supervision was required. A review of training records indicated that all staff were up-to-date with mandatory infection prevention and control training. However, inspectors identified, through talking with staff, that further training was required to ensure staff are knowledgeable and competent in the management of urinary catheters, antimicrobial stewardship and cleaning practices and processes.

- For example, staff had no knowledge of "skip the dip" a national programme to reduce the reliance on urinalysis to check if a resident has a urine infection.

Inspectors were not assured that staff were appropriately supervised in the area of fire safety as they were still using a plug socket that was damaged and this risk had not been reported to or identified by the management team.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that the management and quality assurance systems that would ensure that the service delivered to residents was safe and effectively monitored remained inadequate in a number of areas. Consequently, most of the inspectors' findings on this inspection, some of which required immediate action,

had not been identified by the provider through their own oversight and auditing processes. This was evidenced by;

- Management systems in place did not ensure that the cleaning procedures in the centre were completed to the recommended standards to protect residents from infection and were not in line with local policy. This is a repeat finding and is further detailed under Regulation 27: Infection control.
- The provider had not nominated an appropriate staff member, with the required training, to the role of IPC link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.
- There was poor oversight of complaints procedures to ensure that all complaints were recorded and followed up.
- The governance and management systems had failed to identify that not all reportable incidents had been appropriately and timely notified to the Chief Inspector of Social Services. This is a repeated non-compliance.
- Ineffective systems were in place to monitor fire safety in the centre, further findings are outlined under Regulation 28: Fire Precautions.

Previous commitments given by the registered provider with regard to fire safety were not followed through and inspectors found that not all items on the fire safety risk assessment action plan had been completed within the given time frames. These were areas of risk, in respect of compartmentation of the kitchen and lift.

Judgment: Not compliant

Regulation 31: Notification of incidents

A loss of power in the designated centre which is a notifiable event, as set out in Schedule 4 of the regulations, was not notified to the Chief Inspector of Social Services within the required time frame.

Judgment: Not compliant

Regulation 34: Complaints procedure

- A review of the staff handover sheet identified a complaint from a resident which had not been recorded in the complaints log. Inspectors were satisfied this had been investigated at a local level however, there was no record of the complaint.

- The annual review prepared by the registered provider did not provide a report on the level of residents' engagement with advocacy services and complaints received, including reviews conducted.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The provider had policies and procedures in place as set out in Schedule 5. However, some of these policies required updating to ensure they were up-to-date. Improvement was also required to ensure staff were implementing policies and procedures in relation to IPC practices and complaints.

Judgment: Substantially compliant

Quality and safety

Inspectors found that there were aspects of the quality and safety of care provided to residents that were impacted by inadequate governance and management as described under the Capacity and Capability section of this report. Inspectors found that the quality and safety of care provided to the residents in key areas such as infection control and fire safety did not ensure that residents were adequately protected from an infection and a fire emergency.

The findings of the inspection was that the provider did not comply with Regulation 27 and the National Standards for Infection prevention and control in community services (2018). Weaknesses were identified in infection prevention and control governance, environment and equipment management. Details of issues identified are set out under Regulation 27: Infection and control.

Action had been taken with regard to the maintenance of the premises since the previous inspection and this was evident on this inspection. The provider had relocated the medication room in order to address ventilation issues identified previously. However, this change in the footprint of the centre had not been notified to the Chief Inspector. This inspection found that there continued to be areas of the premises that still required attention similar to the findings of the previous inspection such as damaged tiles and ventilation issues. This and further issues are outlined under Regulation 17: Premises.

Residents had end-of-life care plans in place detailing their preferences and wishes, which varied in the level of detail recorded. The registered provider had a policy and procedure in place pertaining to the management of end-of-life care.

The inspectors viewed a sample of residents' electronic nursing notes and care plans. There was evidence that residents were assessed prior to admission, to ensure the provider could meet their needs. Residents had good access to general practitioners (GPs) and other health and social care professionals. However, based on a sample of eight care plans reviewed, improvement was required to ensure that care plans were sufficiently detailed to guide staff in the care of the residents and were consistently updated in line with residents' changing needs as some care plans were seen to contain conflicting information as outlined further under Regulation 5: Individual assessment and care plans.

The inspectors saw that staff engaged with residents in a respectful and dignified way. Restrictive practices were monitored by the restrictive practice committee who met regularly. Some improvement was required to ensure they fully corresponded with residents' assessed needs and were consistently used in line with national policy.

Inspectors followed up on the compliance plan from the inspection in September 2024 in relation to fire precautions. The registered provider had arranged for a fire safety risk assessment of the centre by a competent person and was formally requested to submit the corresponding action plan to the Chief Inspector. A review of the actions relating to this on the day of the inspection found that important aspects were still outstanding, including compartmentation of some areas to minimise the spread of fire and smoke. An urgent action plan was issued in respect of this and an updated action plan was submitted with a commitment to addressing these areas as a matter of priority. In addition, poor practices were observed by inspectors on the day of the inspection as further discussed under Regulation 28: Fire Precautions.

Regulation 13: End of life

The person in charge had ensured that where a resident was approaching the end of life, the needs of the resident concerned were, in so far as is reasonably practicable, met.

Judgment: Compliant

Regulation 17: Premises

The use of one room in the designated centre was not in accordance with the registered statement of purpose. For example:

- An office had been changed to a medications room.

Some areas of the centre required maintenance and repair to be fully compliant with Schedule 6 requirements. For example:

- Ventilation was not suitable for residents in all parts of the designated centre as two residents' bathrooms did not have adequate ventilation. This was a repeat finding.
- More frequent maintenance was required for areas of the premises for example; the seals around the sink in the kitchen wash-up area were worn and stained, cracked tiles showed exposed concrete and the dry store room fly screen was broken. A plug socket was chipped and coming off the wall in Room 17. Floor covering was coming away from the wall in a sluice room and dirt had gathered here.
- One residents' bath was out of order with no plan in place to repair. A second bath in the centre was available for resident's use.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control. For example:

- The registered provider did not ensure that IPC procedures in relation to environmental hygiene consistent with the standards published by the Authority are in place and are implemented by staff.

- This inspection found that areas of the centre and residents` equipment were visibly unclean and required urgent attention.
- Deep cleaning schedules for residents' rooms were not completed and there was a malodour in some residents' bedrooms.
- Four urinals found in residents' rooms were dirty at the base and had been reused without being cleaned in the bedpan washer.
- There were no water flushing records on the housekeeper's checklist to give assurance that the risk of Legionella bacteria in the water system was being managed appropriately.
- Some barriers to good hand hygiene practices were observed. For example, not all residents rooms had easy access to a hand sanitiser, two hand

hygiene sinks in the laundry room and the kitchen wash-up area were obstructed with equipment and the treatment rooms had no non-risk waste bins for the disposal of paper towels.

The registered provider did not ensure guidance published in relation to IPC and outbreak management was implemented. For example;

- This inspection found that in the preceding month, three residents had respiratory symptoms within a 48-hour time frame, two of which were not tested for Influenza despite instructions from the general practitioner (GP).
- The centre had no supply of swabs to test for respiratory viruses should the need occur.

Judgment: Not compliant

Regulation 28: Fire precautions

This regulation was not looked at in its entirety however, inspectors followed up on the compliance plan from the previous inspection and found that the commitments with regards to fire safety given by the provider had not been fully completed in the following areas and were outstanding for more than six months:

The provider had not made adequate arrangements for containing fires. For example:

- Compartmentation of the kitchen area had not been completed in line with the registered provider's action plan.
- Fire curtains had not been installed on the lift to prevent the spread of smoke and fire.

Furthermore, inspectors found on the day of the inspection that adequate precautions against the risk of fire were not taken at all times, for example:

- A domestic washing machine was plugged into a scorched plug socket via an extension chord. Inspectors were told that a smell of burning in the area had alerted staff the previous week. On the day of the inspection the machine was still plugged in to the socket and staff confirmed it was still in use.
- Fire doors in the conservatory which were damaged, were being held open without automatic closure devices which meant they would not automatically close in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of residents' assessments and care plans found that improvements were needed to ensure they could effectively guide care. Some care plans contained conflicting information and there was a lack of assurance that they were consistently implemented in practice. For example;

- A resident who had been reviewed by their GP had their care plan updated on the same day, however information regarding their wound was not fully recorded in their care plan.
- A resident whose care plan identified that they were using a tracking device for safety did not have a tracker device in place.
- A resident who was using a sensor alarm did not have this recorded in their care plan.
- The personal evacuation plan in place for a resident in the event of a fire contained information contradictory to their mobility care plan.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP) of their choice.

Residents also had access to a range of health and social care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life, and palliative care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

- While there was a restrictive practice register in place on the day of the inspection this was found to not be fully accurate and required further review as some interventions named on the register were found not to be in place when checked against the resident's care plan.
- From a sample of eight residents' care plans reviewed two residents did not have alternatives trialled recorded on their restrictive practice assessments.

- One resident's restrictive practice assessment was not fully completed for their bed alarm.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider was not a pension agent for any resident in the centre. There were no safeguarding incidents recorded in the centre since the previous inspection. Staff had received appropriate training in relation to the detection and prevention of and responses to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

While residents' rights were mostly upheld in the centre. Two twin bedrooms did not have appropriate privacy curtains in place on the day of the inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: End of life	Compliant
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 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

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

Inspection ID: MON-0047251

Date of inspection: 22/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Further training has commenced and is being rolled out across the home to ensure staff are knowledgeable and competent in the management of: o Urinary catheter care and antimicrobial stewardship training. o IPC awareness posters are now displayed throughout the home with emphasis on cleaning practices and "Skip the Dip" o Additional training for Household staff on 'Clean Pass' is due to commence. o Toolbox talk are being conducted weekly in relation to at the morning handover meeting which includes the staff from night duty. • A full environmental audit was conducted following the inspection to identify and address any outstanding maintenance or safety concerns, including the damaged plug socket, which was removed/replaced. • New daily walk around audits have commence in the home and are being conducted by the Director of Nursing, Clinical Nurse Managers and members of the Senior Team within the home. Any issues identified that a minor are actioned immediately. All other issues are identified and assigned to an individual and completion within a specific timeframe. • The maintenance reporting system has been reviewed and staff reminded of the importance of promptly reporting health and safety risks. These risks are logged on the maintenance system and brought to the attention of the Director of Nursing or Senior team within the home. All risks are logged on the live risk register.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

The management and quality assurance systems have been reviewed and updated within the home to ensure that the service delivered to residents is safe and effectively monitored. This is being achieved by iplementing the below proccesses:
On July 23, a meeting was held with the household supervisor, Group Operations and Procurement Manager, DON, and HR to discuss the noncompliance with environmental hygiene and resident equipment. Actions from this meeting were:
• A review the Household roster was completed, and it was adapted to ensure that adequate staffing levels are in place each day. There are now 4 household staff on during the week with oversight in place by the Household Supervisor.
• A deep clean of all equipment was conducted following the inspection and signed off by the household manager and Director of Nursing.
• An updated cleaning checklists was put into place to ensure a more robust auditing system with oversight from the Director of Nursing. The Director of Nursing will conduct a spot check on rooms in the home to ensure it is cleaned at a high standard. This includes all pull-outs of beds and cabinets and deep cleanings of each resident's room.
• An updated plan of deep cleaning has been put in place for the Household staff.
• Twice weekly meetings with the Director of Nursing, HR Manager and Household supervisor have commenced to discuss any concerns or issues identified during the walk around. All actions and responsibilities will document, and completion dates agreed.
• At the above meeting the weekly audits carried out by the Household supervisor will be reviewed. These will also include the cleaning checklists being carried by the nighttime HCA's.
• A new IPC link nurse has already completed the IPC link practitioner program on HSELand and is on the waiting list for the IPC link program offered by HSE CHO9 in an effort to enhance the administration and governance of IPC in St. Gabriel's. This is to ensure that the overall level of IPC in St. Gabriel's is brought up to the required standard. When the programme is completed the IPC link nurse will carry out further IPC awareness training with all staff. Until this has been completed the CNM, Director of Nursing and IPC link will conduct monthly IPC and environment audits. Additionally, all staff members in the home will be observed to assess their overall continuous performance and, if necessary, provided extra training.
• To enhance the Governance and Oversight within the home the group has begun recruitment for a third CNM in St Gabriels Nursing Home. This CNM post will oversee IPC practices and compliance in collaboration with the Director of Nursing.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• Going forward, any similar incidents happening in future will be reported and notified to chief inspector within two working days as per the HIQA guidelines.

Regulation 34: Complaints procedure	Substantially Compliant

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

• The identified complaint has since been documented in the complaints log, with full details of the concern, actions taken, and outcome.
• All staff have been reminded of the requirement to log all complaints, including those resolved locally, in accordance with the centre's complaints policy and Regulation 34.
• The 2025 annual review template has been updated to include:
o A section on resident engagement with advocacy services (including informal and formal interactions).

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

• Since the inspection, we have commenced a full review of all policies listed under Schedule 5 to ensure they are current, aligned with best practice, and compliant with regulatory requirements. This review process has been scheduled on a rolling basis with clear timescales for completion and ongoing review dates to maintain compliance. In relation to IPC practices and complaints, we have implemented additional staff training and refresher sessions to reinforce understanding and ensure consistent application of policies in day-to-day practice. Regular audits and supervision checks are now in place to monitor compliance and provide early identification of any gaps. We are also introducing spot checks and feedback mechanisms to strengthen accountability and embed these practices within the service.
• These measures will support continuous improvement and ensure that policies are both up-to-date and effectively implemented in practice.

Regulation 17: Premises	Substantially Compliant

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

• The Statement of Purpose has been updated to reflect the new use of the room by registered provider on 21/08/25
Maintenance and Repair Deficits:
Following the Inspection the Group Maintenance Manager and Group Operations and Procurement Manager conducted a comprehensive maintenance audit of the home.
• The following actions have been completed or are underway:
o Bathroom ventilation: Extraction fans will be repaired or replaced.

o Kitchen sink seals: Replaced and resealed on 15/08/25.
o Cracked tiles and concrete: Repairs ongoing.
o Dry store fly screen: Deep cleaned.
o Plug socket in Room 17: Removed and replaced by a qualified electrician.
o Sluice room floor: Flooring for repair and area deep cleaned.
o The bath currently out of order has been assessed and a repair plan is now in place. Residents continue to have access to an alternative bath, ensuring their needs are met while repairs are being completed.
We are committed to maintaining a safe and well-maintained environment for residents and have strengthened our monitoring and maintenance systems to ensure ongoing compliance with Schedule 6 requirements.
Ongoing Measures:
• A preventative maintenance schedule has been implemented to identify issues before they impact residents.
• A weekly environmental walk-through is now conducted by the Director of Nursing and Maintenance Manager to ensure standards are maintained.
• A maintenance logbook is accessible to all staff for timely reporting of issues.

Regulation 27: Infection control	Not Compliant

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

• The following actions have been taken and are being implemented to ensure safe, effective, and sustainable IPC governance arrangements:
• A deep clean of all equipment was conducted on the 23rd and 24th July and signed off by the household manager and Director of Nursing. An updated plan of cleaning residents equipment is now in place.
• All urinals identified were removed from use immediately and replaced with appropriate alternatives.
• Cleaning practices have been reinforced and monitored to ensure all reusable equipment is decontaminated correctly using the bedpan washer or other approved methods.
• To increase IPC awareness, one staff member per floor is designated as the IPC champion on duty each day to ensure all staff members receive a daily IPC check handover.
• An updated cleaning checklists was put into place to ensure a more robust auditing system with oversight from the Director of Nursing. This includes all pull-outs and deep cleanings of each resident's room.
• Review the roster and adapt it to ensure that adequate staffing levels are in place each day.
• Water flushing records are now maintained daily by housekeeping staff and audited weekly by the Director of Nursing to ensure compliance.
• Obstructions at hand hygiene sinks in the laundry and kitchen have been removed, with new protocols introduced to prevent recurrence.
• Non-risk waste bins for disposal of paper towels have been installed in treatment

rooms.
• Twice weekly meetings with the Director of Nursing, HR Manager and Household supervisor to discuss any concerns or issues identified.
• At the above meeting the weekly audits carried out by the Household supervisor will be reviewed.
• To prevent any confusion going forward any Resident who exhibits respiratory symptoms will be kept in isolation, reported to the GP, CNM, and DON, and tested using COPAN swabs. The senior nurse or CNM on duty will continue to assist the GP on their weekly rounds.
• The home has since linked with CH09 who attended the nursing home on the 28/07/2025. They provide guidance and support to the Director of Nursing and CNM's around the area of Respiratory symptoms in residents.

St Gabriels Nursing Home is committed to embedding these changes into practice to ensure the delivery of safe, effective, and sustainable infection prevention and control in line with regulatory standards.

Regulation 28: Fire precautions	Not Compliant

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

We accept that the commitments made in our previous compliance plan had not been fully achieved. We recognise the seriousness of these matters and have taken immediate action to address the risks identified.
• The registered provider has engaged with a competent Fire contractor to carry out works to ensure Compartmentation of the kitchen area.
• Installation of fire curtains has been commissioned and is scheduled for completion. In the interim, additional risk control measures have been put in place, including enhanced fire drills and staff checks in the vicinity of the lift.
• A certified electrician removed the scorched socket and extension and replaced it with a new socket.
• Damaged fire door in conservatory: The registered provider is engaging with a competent Fire contractor to carry out works to ensure fire safety.
The Group Maintenance Manager will link with the homes maintenance individual to monitor fire precautions and ensure all remedial works are completed within agreed timeframes.
Weekly fire safety checks, including fire doors, electrical sockets, and compartmentation controls, are now documented and audited by the management team.

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:

• All residents' care plans are currently being reviewed in full to ensure accuracy, consistency, and alignment with GP reviews and multidisciplinary input.
• The following actions are being completed:
o Wound care documentation: Updated for the resident in question to include full clinical details and treatment plan. Same will be continued for all residents in future as needed.
o Care plans have been updated to ensure the use of assistive technology (e.g., tracking devices, sensor alarms) is clearly recorded, with rationale for use and monitoring arrangements documented. The resident identified as using a tracking device had this intervention reviewed. As the device was no longer in use, the care plan was updated accordingly. A process is now in place to cross-check devices in use against care plans during monthly audits to ensure accuracy.
o Tracker device:
o Sensor alarm: The restraint screening assessment, careplan, assessment tool, and consent forms are updated for all residents using restraints.
o PEEP vs mobility plan: All personal evacuation plans (PEEPs) were reviewed and aligned with mobility care plans to ensure consistency and accuracy.
Care plan audits are been overseen by the clinical nurse manager, to identify discrepancies and ensure corrective actions are taken promptly. Supervision and spot checks are being carried out to confirm care plans are consistently implemented in practice by the Director of Nursing. Ongoing training and support are being provided to staff to strengthen documentation skills and reinforce the importance of accurate care planning.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

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

• The restrictive practice register has been fully reviewed and updated to ensure accuracy and alignment with residents' care plans. A new process is in place to cross-check the register against care plans on a monthly basis to ensure consistency and accuracy.
• The Restrictive Practice Register has been fully reviewed and updated to reflect only current, active practices in place.
• All residents listed on the register were audited, and their care plans were updated to ensure alignment with the register.The restrictive practice assessments for the identified residents were updated to include:
o A record of alternatives trialled and considered prior to implementing any restriction.
o Completion of all relevant fields, including the previously incomplete bed alarm assessment.

A quarterly multidisciplinary review will continue, with findings reviewed at governance

meetings to ensure sustained compliance. Residents' care plans and restrictive practice assessments are being reviewed in consultation with residents and/or their representatives to ensure practices are proportionate, least restrictive, and clearly justified

Regulation 9: Residents' rights	Substantially Compliant

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

• Reminded staff to ensure the curtains are replaced with the spare ones once it is taken for washing.
• Staff have been reminded through team meetings and supervision of the importance of maintaining residents' privacy at all times.
• Residents are being consulted regularly on their comfort and privacy through resident meetings and individual keyworker sessions.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	20/08/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/08/2025
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	31/10/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular	Substantially Compliant	Yellow	31/10/2025

	designated centre, provide premises which conform to the matters set out in Schedule 6.			
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.	Substantially Compliant	Yellow	31/10/2025
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	Red	31/12/2025
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.	Not Compliant	Red	30/07/2025
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to	Not Compliant	Red	30/07/2025

	infection prevention and control and outbreak management is implemented in the designated centre, as required.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/09/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	30/07/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on	Substantially Compliant	Yellow	20/08/2025

	foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
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 provided on the level of engagement of independent advocacy services with residents.	Substantially Compliant	Yellow	31/10/2025
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	31/10/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	05/09/2025
Regulation 04(3)	The registered provider shall	Substantially Compliant	Yellow	30/09/2025

	review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	05/09/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	05/09/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance	Substantially Compliant	Yellow	05/09/2025

	with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	23/08/2025