



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

Issued by the Chief Inspector

Name of designated centre:	Saint Louis Nursing Home
Name of provider:	Yvonne Maher
Address of centre:	1-2 Clonmore, Ballymullen, Tralee, Kerry
Type of inspection:	Unannounced
Date of inspection:	23 July 2026
Centre ID:	OSV-0000289
Fieldwork ID:	MON-0044006

About the designated centre

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

St. Louis Nursing Home is a two-storey premises based in the town of Tralee and close to amenities such as shops, restaurants, and a library. While it is a two-storey building, all resident accommodation is on the ground floor. The centre provides 24-hour nursing and social care to 25 residents, both male and female, who are predominantly over the age of 65 years. The centre offers long and short-term care, respite and convalescence care. Bedroom accommodation comprises 15 single bedrooms and five twin bedrooms. Three of the single bedrooms are en suite with shower, toilet and wash hand basin. The aim of the nursing home, as set out in the statement of purpose, is to provide a high standard of professional care to residents in a safe and homely environment, while preserving and promoting independence.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25
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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
Thursday 23 July 2026	10:00hrs to 18:10hrs	Siobhan Bourke	Lead

What residents told us and what inspectors observed

This was an unannounced inspection, conducted over one day, by an inspector of social services. The inspector met with many of the residents and spoke with eight residents in more detail, to gain an insight into their experience of living in the centre. Based on the observations of the inspector and discussions with residents, it was evident that Saint Louis Nursing Home was a nice place to live. Residents spoke very positively regarding the kindness and care they received from staff working in the centre. Staff were seen to be familiar with the residents' needs and preferences and were observed to be respectful in their interactions with residents. However, the inspector identified some deficits in the governance and management systems, that are discussed further in the report.

On arrival, the owner of the centre and the person in charge greeted the inspector. The inspector walked around the centre to meet with residents and to observe the activities in the centre. The inspector observed a friendly and calm atmosphere, with staff supporting residents, in accordance with their individual routines and preferences. Some residents were being assisted with their personal care and others were sitting in the dayroom, ready for the day's activities. Discussions with residents confirmed that their daily routines, including when they got up, retired to bed and how they spent their day, were based on their personal choices.

Saint Louis Nursing Home provides care for both male and female adults, with a range of dependencies and needs. The centre is situated in the town of Tralee, in County Kerry, and is registered to accommodate 25 residents and was fully occupied on the day of inspection. It is a two-storey facility, with residents' accommodation all located on the ground floor and staff facilities and storage located on the first and second floor.

Bedroom accommodation comprises 15 single and five twin bedrooms. Three single bedrooms have en-suite facilities, and the remainder of the bedrooms have shared toilets and showers. Grab rails were not available in the toilets as required in the regulations. The inspector saw that flooring had been replaced in some of the residents' bedrooms and corridors. The call bell system was also upgraded and a new panel installed. Many of the bedrooms were personalised with items of importance to residents. The inspector saw that privacy curtains in the twin rooms were not aligned to ensure that both residents could have privacy, when the curtains were closed. The position of the television in the twin rooms did not ensure both residents had equal access to watch television, should they choose to do so. This will be discussed further in the report.

The centre had three communal rooms, that were observed to be clean and homely on the day of inspection. There was a large day room, a dining room and a quiet room available for residents' use. The inspector saw that these rooms were well maintained. Residents could easily access the secure internal courtyard, which had

seating and tables for residents' use. A few gazebos were also present to provide shade during the summer and were used during the recent summer barbecue that several residents told the inspector was a great afternoon. The inspector saw that the day room door was missing a handle and was not connected to the centre's fire alarm. While some residents' bedrooms had closing devices fitted to ensure they close automatically on activation of the fire alarm, many did not. This will be discussed under Regulation 28 Fire Precautions.

The inspector observed the lunchtime meal and saw that residents were provided with a choice of main courses. Residents gave positive feedback to the inspector regarding the choice and quality of the home cooked meals provided to them. Residents were offered a choice of menu options, including dessert, and drinks. The inspector saw that residents who required assistance were provided with this in a respectful and unhurried manner. Many of the residents choose to eat their meals in the dining room. This room was very homely, and residents were chatting together during the meal.

Visitors were welcomed in the centre and visitors who spoke with the inspector confirmed that there were no restrictions in place. Visitors were seen in residents' bedrooms and communal areas.

During the day, the inspector spent time observing residents' daily lives and their interactions with staff. The inspector saw many person centre interactions between staff and residents during the day. Residents who spoke with the inspector reported that their call bells were answered promptly when they sought assistance. Staff were observed knocking before entering residents' bedrooms and were respectful in their interactions with residents. Residents were supported to go on outings from the centre independently in line with their capacities or with relatives and friends.

In the morning, the activity co-ordinator was engaging with residents through both one-to-one and small group activities. A volunteer advocate also spent the full day in the centre, chatting and listening to residents. In the afternoon, an external musician attended the day room, and a lively sing song ensued, with residents and staff dancing together. Residents who spoke with the inspector were very complimentary regarding the activity staff and the live music sessions held once a week. It was evident that residents were consulted about what was happening in the centre. Residents' meetings were held each quarter, and the views and opinions of residents were documented. A survey to seek residents and their relatives' views on the service provided was completed each year. Action plans following meetings and surveys were developed. Residents had access to a complaints policy which was on display in the centre, together with advocacy services available to them.

The next two sections of the report describes the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered to residents. Areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This unannounced risk inspection was carried out by an inspector of social service to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended) and to follow up on the compliance plan submitted by the provider following the previous inspection of the centre.

The findings of this inspection identified significant deficits in the provider's governance and management arrangements, as evidenced by inadequate oversight by the provider and management team regarding fire precautions and premises issues in the centre.

Saint Louis Nursing Home is owned and operated by Yvonne Maher, a sole trader, who is the registered provider, and works full time in the centre. Residents' clinical and social care is directed by a suitably qualified person in charge, who leads the team in a management and supervisory role. They are supported in their position by an assistant director of nursing and a team of nursing staff, health care assistants (HCAs), household, activities and administrative staff. The management structure was clearly defined and identified lines of authority and accountability. The assistant director of nursing deputised for the person in charge in their absence.

The inspector saw that the number and skill mix of staff on the day of inspection was appropriate to meet the assessed needs of the 25 residents living in the centre.

There was a registered nurse on duty at all times, supported by the person in charge and a team of healthcare assistants. There were two activity staff employed in the centre to support the activity schedule for residents.

The provider maintained a training matrix to monitor staff uptake of mandatory training in the centre. All staff were up to date with managing responsive behaviour and all staff had completed infection control training. A number of staff were overdue training in manual handling and this was scheduled to be held in the coming weeks. Two staff had not completed safeguarding training and staff were also overdue refresher fire training as outlined under Regulation 16; Training and staff development.

The person in charge maintained a schedule of audits to monitor the clinical care provided to residents and overall good compliance was found in these audits. Weekly clinical care indicators such as residents with pressure ulcers, falls, restrictive practices, antibiotic usage was also monitored. The provider held regular meetings with staff to communicate any changes in the home or residents' needs with staff. An annual review of the quality and safety of care provided to residents had been prepared for the previous year as required in the regulations. However, the inspector was not assured that the systems in place to ensure oversight of fire

safety in the centre were effective as outlined under Regulation 23 Governance and management.

The inspector reviewed records of complaints maintained in the centre and saw that complaints were recorded and actioned by the person in charge, who was the complaints officer for the centre. Where required written responses were sent to complainants. From a review of these responses while they did contain the actions taken arising from the complaint, they did not include details of the review procedure as required in the regulation. This is detailed under Regulation 34 Complaints procedure.

A record of incidents occurring in the centre was maintained by the person in charge and from a review of these records, it was evident that required notifications were submitted to the office of the Chief Inspector as required.

Regulation 15: Staffing

The number and skill mix of staff was appropriate to meet the assessed needs of the 25 residents living in the centre at the time of the inspection. From a review of the rosters and from speaking with staff and management, there was a registered nurse rostered in the centre 24 hours a day as required in the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

From a review of the training matrix, it was evident that action was required to ensure all staff attended mandatory training in line with the centre's policy. Two new staff working in the centre had not completed safeguarding training. A number of staff were overdue annual fire safety training.

Judgment: Substantially compliant

Regulation 23: Governance and management

Action was required with regard to the management systems to ensure the service is safe, appropriate and effectively monitored with regard to fire safety and premises as evidenced by the following;

- Drills to simulate evacuation of the largest compartment in the centre when staffing levels were at their lowest were not undertaken frequently enough to

provide assurance that residents could be evacuated in a timely manner. An immediate action was issued on the day of inspection to complete this and submit to the office of the Chief Inspector. This was actioned by the provider. • There was a lack of oversight of the systems in place to ensure fire safety, as gaps in the servicing of fire equipment, and other fire safety precautions were not in place. • There was a lack of oversight of risk assessment for residents as the inspector saw that a residents emergency evacuation plan was not in line with the residents needs. This was actioned on the day of inspection. • The compliance plan timelines submitted by the provider following the previous inspection with regard to the installation of door closing devices and other fire safety works completion date in the centre had not been met. • There was a lack of oversight of the systems in place to ensure the premises are maintained in line with Schedule 6 as outlined under Regulation 17; Premises.
Judgment: Not compliant
Regulation 31: Notification of incidents
A record of incidents was maintained in the centre. The inspector reviewed these records and found that required notifications had been submitted to the office of the Chief Inspector in a timely manner
Judgment: Compliant
Regulation 34: Complaints procedure
Action was required to ensure compliance with the regulations as from a review of that written responses to complainants, these did not include details of the review process and review officer. This is required so that complainants could seek a further review of their complaint if they were not satisfied with the investigation of their complaint.
Judgment: Substantially compliant
Quality and safety

The inspector found that residents living in St. Louis Nursing Home were supported to have a good quality of life by staff who were kind and caring. There was a rights-based approach to care; both staff and management promoted and respected the rights and choices of residents living in the centre. Residents lived in an unrestricted manner according to their needs and capabilities and there was a very low use of restrictive practices in the centre. Residents had good access to healthcare services and had daily opportunities to participate in group activities. However, action was required regarding Fire precautions and premises as outlined under the relevant regulation.

The inspector reviewed a sample of residents' records and saw that nursing and healthcare records were maintained in paper format. Residents care plans were developed using validated assessment tools and were updated every four months or when a residents condition changed. There was evidence that residents were regularly reviewed by GP from local GP practices. Residents were referred where required to allied healthcare professionals such as physiotherapists, speech and language therapists and dietitians.

There was a low use of restrictive practices in the centre and staff were up to date with training on the management of responsive behaviours. During the day, the inspector saw that staff engaged with residents in a respectful and person-centred manner. Residents were encouraged to go on outings from the centre with relatives or independently depending on their capabilities.

Many residents gave positive feedback to the inspector regarding the choice and quality of the home cooked food in the centre and the inspector saw that the dining experience was a sociable one for residents.

Two members of the nursing team had completed link nurse training in infection prevention and control. The inspector saw that residents' bedrooms were cleaned every day. The provider had taken action with regard to the findings of the previous inspection in infection prevention and control and had installed new hand hygiene sinks. Some further action was required with regard to infection control as outlined under Regulation 27; Infection Control.

The inspector saw that communal areas in the centre comprised a large day room, a dining room and a quiet room that were available for residents' use. Residents could freely access the small secure internal courtyard that had seating and sunshades for the summer weather. A number of bedrooms had been recently painted, however privacy curtains in shared rooms required review as they did not provide privacy for residents and grabrails were missing from the toilets. These and other findings are outlined under Regulation 17; Premises.

The inspector saw that the provider had taken some action with regarding fire precautions following the findings of a previous inspection of the centre. The provider installed an appropriate hold open device to the kitchen door so that it would close automatically in the event of the fire alarm being activated. A gas shut off valve had also been installed in the kitchen. A new fire door had been fitted in the dayroom and new electrical sockets had been repositioned and fitted in many

residents bedrooms to reduce the usage of extension leads. However further action was required with regard to fire precautions as outlined under Regulation 28; Fire Precautions.

Residents views were sought through regular resident's meetings and surveys. On the day of the inspection, a resident advocate was onsite visiting and chatting with residents. There was a good schedule of activities available for residents and two activity staff facilitated both group and one-to-one activities. Residents had access to independent advocacy services as required.

Regulation 17: Premises

Not all aspects of the premises conformed to the matters set out in Scheduled 6 of the regulations as evidenced by the following;

- The inspector saw that privacy curtains in shared bedrooms were not available around both beds so that both residents could have their privacy.
- One of the door handles was missing from one of the day room doors, which may make it difficult to open.
- Grab rails were not in place around the toilets in the centre as required under Schedule 6.
- Some wear and tear was evident to the walls and woodwork in residents' bedrooms.
- Some residents' bedrooms were missing chairs for residents or their visitors to use.

Judgment: Not compliant

Regulation 18: Food and nutrition

The inspector saw that residents had a choice of meals for the lunch time and evening meals in the centre. Residents who spoke with the inspector gave positive feedback on the choices and quality of food provided to them. The inspector saw that residents who required assistance were attended to in an unhurried and dignified manner. Residents weights were monitored closely in the centre and from a review of a sample of residents' records, it was evident that residents were referred to speech and language therapists or dietitians as required and their recommendations were reflected in care planning.

Judgment: Compliant

Regulation 27: Infection control

Action was required to ensure that procedures consistent with the standards for the prevention and control of health care associated infections published by the HIQA were in place and were implemented by staff as evidenced by the following;

- A bedtable was noted to be rusted and therefore could not be effectively cleaned.
- A staff member was observed to miss the opportunity to comply with hand hygiene when providing care to a resident as required.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While the registered provider had actioned some of the findings of the previous inspection of the centre regarding fire precautions; the inspector was not assured that the registered provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire. As evidenced by the following;

- While fire drills were being undertaken in the centre; they were not performed cognisant of minimum staffing levels and compartment sizes so that the provider was assured that residents could be safely evacuated in the event of a fire. An immediate action was issued to the provider on the day of the inspection in this regard. The provider submitted a report of a fire drill following the inspection.
- A review of a resident's personal emergency evacuation plan indicated that they required a ski sheet evacuation; however, this was not in place on the residents' bed, a further assessment by staff identified that this method was not in line with the resident's needs.
- The fire door leading from the day room was not connected to the fire alarm, as outlined in the compliance plan submitted by the provider.
- 11-bedroom doors did not have automatic closing devices to ensure they would close automatically in the event of a fire and there was not a system of checking them in place.
- The provider did not make adequate arrangements for maintaining of all fire equipment as from a review of records fire extinguishers had not been serviced in the last 12 months.
- Testing of the fire alarm was not conducted every week to provide assurance that it was in working order.
- While records were available to indicate that the fire alarm and emergency lighting was serviced each quarter, annual certification records were not available.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of three care plans and found that residents had a care plan developed within 48 hours of admission to the centre. Care plans reviewed were found to be person-centred and detailed to direct residents' care. Care plans reviewed were updated four monthly and when a resident's condition changed.

Judgment: Compliant

Regulation 6: Health care

From a review of residents' records and from speaking with residents and staff, it was evident that residents had good access to medical assessments and review by a general practitioner (GP). Staff working in local community services such as team members from Integrated Care Programme for Older Persons (ICPOP) attended the centre to review residents where required as did the local palliative care team and community mental health team.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff were knowledgeable regarding residents who experienced responsive behaviours and were observed providing care in a respectful and person centred manner. There was a low use of restraint such as bedrails in use the centre and evidence of alternatives such as crash mats were in use.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted regarding the running of the centre, through regular resident meetings. There was evidence that feedback from residents was acted on by the management team. Residents had access to independent advocacy services as required. There was a schedule of activities available for residents which enabled

residents to participate in meaningful and interesting activities including group and one to one activities.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Saint Louis Nursing Home OSV-0000289

Inspection ID: MON-0044006

Date of inspection: 23/07/2026

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: All mandatory training including FIRE WARDEN has been completed on 13th and 14th august 2026. Certificates issued by training company. Some staff are due to attend patient and manual handling training next week to bring their training up to date. Training for staff due 'safe guarding' had been provided and all staff members have received due training to ensure they can provide behavioural support and protection to our residents and uphold their rights. Matrix of all training maintained to ensure training in secured and delivered in advance of date/year due.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: On 6th August audit of governance and management of the n.h. Was carried out by an independent auditor in health and safety matters. The results of this audit have been analysed and shortcomings identified are in the process of being addressed and rectified. To demonstrate good governance, the provider undertakes to promote fire safety awareness in the centre. Therefore, fire safety will be included as a standard agenda for all management meetings going forward. Fire safety awareness will be promoted amongst all staff and the identification and management of fire risks will be undertaken to ensure the safety of all residents and staff in the centre. The provider and management will make sure that the fire fighting equipment and evacuation plan will be reviewed and kept up to date with new and emerging practices relating to fire safety.	

Clear lines of authority and accountability at all levels for fire safety have been identified at management, individual and team levels. This will help ensure that everyone in the centre is safe from the risk of fire and that all legal requirements are being met. A fire safety management plan/policy will be revised to show how the home organises, controls, monitors and reviews fire safety precautions specific to St. Louis nursing home. This will be done in co-operation with the assistance and findings of the independent fire officer who audited the home on 6th August 2026.

(A) All outstanding action plans from this and previous Hiqa inspections will be completed and closed within an agreed time frame and evidence retained to demonstrate compliance and continuous improvement. (B) Management structures have been redefined and responsibilities have been allocated to ensure everyone involved in management is aware of their specific roles and responsibilities. This will ensure accountability and responsibility and clearly defined roles for the successful and safe running of the home. (C) Fire training and the successful evacuation of the largest compartment with minimum amount of staff on duty (night duty) will be regularly carried out on a weekly basis. (D) Management have increased the number of staff on night duty from two staff to three staff. This will greatly assist evacuation in the event of a fire and will also provide a safer environment for all residents. (E) All p.e.e.p.s will be reviewed to ensure they reflect resident's needs and capabilities. (D) All fire fighting equipment has been inspected, updated and signed. (E) Annual certificates for servicing fire fighting equipment, fire alarm and emergency lighting available on file for inspection. (F) Bedrooms and communal rooms will be maintained and will be neat and nicely decorated to ensure the wellbeing of our residents and to. (G) Management will ensure a comfortable chair is provided in all bedrooms to allow family members and friends visit in the comfort of resident's own room. (H) All doors are fitted with automatic closing devices and are connected to the alarm system. This will allow doors to close automatically when the fire alarm sounds and comply with Hiqa regulations. (I) Privacy curtains will be provided in all double bedrooms to ensure the curtain surrounds the complete cubicle. The curtain rails will be replaced to provide complete privacy and no cubicle is visible on entering the room.

Regulation 34: Complaints procedure

Substantially Compliant

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

As per section 10 of the Health Act 2007 it is imperative to have a robust complaints procedure ensuring it is accessible and effective and including an appeals procedure. Complaints procedure is displayed in reception and visible to all. If necessary staff will assist residents or their families to log and understand the complaints procedure. Complaints are logged and detailed in the 'complaints register'. Investigation into each complaint is carried out by person in charge and the care provider. Complaints are investigated immediately and a quick resolution is sought. (There is an independent advocate available to the residents and their families if the complainant would rather

speak to someone who is not employed by the nursing home.) Instructions on how to escalate the complaint will be provided to all complainants when the findings are issued. This will assist the complainant in taking their complaint to a higher level of authority should they wish to do so now or in the future. A letter of apology from management and staff will be issued where a complaint is upheld and identifying proposals to remedy or improve the issue or the service that was the cause of the complaint. A follow up meeting will be arranged with the complainant to ensure they are happy with the outcome of their complaint and that remedies introduced to prevent a recurrence are robust and genuine. We welcome complaints and view them as positive as it provides the opportunity to do better and provide a better service.

Regulation 17: Premises	Not Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises: Maintaining the premises is an on-going task. Maintenance man on site three to four days each week and on call to attend 24/7. Paint work is frequently scratched during the cleaning and moving of beds and furniture in the rooms and we are presently identifying ways to help preserve the paintwork and avoid scratches and markings to freshly painted walls and timber work.

On going decoration and improvement continues and there has been a huge expenditure in upgrading furniture and soft furnishings this year. All rooms have had a makeover with newly painted walls and co-ordinating bed linen and curtains. Each compartment has been decorated in a distinct colour and the overall effect is impressive. (B) New privacy curtains have been ordered for all double rooms and curtain rails/trackings have been redesigned to allow complete privacy to both cubicles in all our double rooms.(C)Regular walk-arounds by Care Provider to identify areas in need of improvement/decoration and to ensure all areas are clean/bright and in good order. (D)Comfortable armchair provided in each bedroom to allow a comfortable visit for family/visitors. Grab rails installed in all bathrooms and toilets to provide support for residents. This will reduce the risk of falls. (E)Safety of all residents is of paramount importance in the nursing home. It is of utmost importance that a safe environment is maintained at all times. Solid custom made gate ordered for the back entrance to the home. This gate will be operated open/closed by a pin pad/code to ensure only authorised personnel can open/close this gate. This gate will be installed my mid september. Treble lock system in place to prevent absconsion from the home. Kitchen door closed when chef is off duty. Kitchen door to the back garden closed and new gate to back driveway will be locked and operated by pin-code to ensure no resident can leave the home without supervision.

Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: Regular audited hand-washing for all staff to ensure it continues to be a routine practice in the home. Impromptu audits to ensure all staff use and are familiar with the correct technique for hand washing. Disinfectant hand gel supplied to all staff and available for use at all times. It is carried on the person. Ample supply of hand sanitising dispensers in the nursing home to ensure everyone can disinfect their hands at anytime. Daily cleaning of the home using colour coded clothes to reduce the risk or spread of cross infection. Colour coded clothes introduced for kitchen cleaning to reduce risk of cross infection. Two trained I.p.c. nurses on duty to advise and direct staff towards maintaining and upholding our infection control policies and to observe and police staff on duty to ensure they are observing all infection control measures. All staff have been requested to access hiqa ipc digital learning module to align day to day practices with inspection criteria. Proper segregation and storing of domestic and clinical waste continued and collected routinely by registered waste disposal contractors. Daily cleaning and weekly deep cleaning continued and documented by cleaning staff. New pre-admission assessment and transfer forms redesigned to include any active or know history of past infections including hospital acquired or community acquired infections. This will allow the opportunity to isolate/treat/request negative result before admission/discharge from the hospital/home. Continued use of p.p.e as required and staff knowledgeable in donning/doffing of same.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. Extra staff member rostered for night duty increasing total of staff on nights from two to three. This will enable faster evacuation from the home in the event of fire. 2. Mandatory Fire training completed 13th and 14th August by all staff. This included ski sheet and wheelchair evacuation from the home. 3. Fire fighting equipment checked every quarter and annual certificate available to demonstrate checks were completed 4. Fire extinguishers in the home serviced 13th august and checks dated and signed. 5. Automatic door closures installed in all rooms and connected to the alarm system to ensure all doors automatically close When the fire alarm is activated. (6) Inspection of home by Fire Officer on 17-08-26 to ensure compliance with local fire requirements (7) Weekly fire drills in the n.h every Monday and Thursday to ensure all staff receive frequent practice evacuating the compartment/building within the allowed time frame. Fire drills recorded/attendance taken/skills refreshed regularly. (8) Fire prevention check lists daily/weekly/monthly introduced to ensure compliance with fire regulations (9) Fire training with residents to explain evacuation drill and to familiarise them with the sound of the fire alarm. (10) Emergency lighting and exit sinage visible, serviced and updated (11) directional sinage increased displaying fire exit routes (12) All electrics in building recently updated and use of extension leads discontinued. (13) Eircode sinage displayed	

throughout the building to allow immediate contact with emergency services.
Fire and fire safety awareness is promoted in the home and fire safety will be included in all management meetings going forward. The care provider will undertake to ensure that training and services keep up to date with new and emerging practices and technologies relating to all fire safety.

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	16/09/2026
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.	Not Compliant	Orange	30/09/2026
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	16/09/2026
Regulation 27(a)	The registered provider shall ensure that	Substantially Compliant	Yellow	30/09/2026

	infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.			
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.	Not Compliant	Orange	16/09/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	16/09/2026
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	14/08/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures,	Substantially Compliant	Yellow	14/08/2026

	building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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.	Not Compliant	Orange	14/08/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	14/08/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of	Substantially Compliant	Yellow	16/09/2026

	a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
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