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:	Aisling House Nursing Home
Name of provider:	Hussein & Jeanette Ali Limited
Address of centre:	Sea Bank, Arklow, Wicklow
Type of inspection:	Unannounced
Date of inspection:	24 February 2026
Centre ID:	OSV-0000003
Fieldwork ID:	MON-0046021

About the designated centre

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

Aisling House Nursing home is a single-storey centre, which provides residential care for 50 people. It provides care for both male and female adults with general care needs within the low, medium, high and maximum dependency categories. A pre-admission assessment is completed in order to determine whether or not the service can meet the potential resident's needs. Twenty-four-hour nursing care is provided. There were 34 single bedrooms, 23 of which had en-suite facilities and eight twin bedrooms, five of which had en-suite facilities. Each bedroom was appropriately decorated and contained personal items such as family photographs, posters and pictures. Communal space included a day room, three sitting rooms and two dining rooms. There was a well maintained internal courtyard. Adequate parking was available at the front of the building.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

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 24 February 2026	08:05hrs to 16:20hrs	Niamh Moore	Lead

What residents told us and what inspectors observed

This was an unannounced one-day monitoring inspection of Aisling House Nursing Home. Based on the observations of the inspector and discussions with residents and staff, Aisling House Nursing Home was a nice place to live. Management and staff knew residents' needs well and there was a welcoming and homely atmosphere in the centre. When speaking with the inspector, residents spoke positively about their lived experience in the centre. One resident said that "I am very happy here" and "the staff are great".

The inspector was introduced to the person in charge on arrival at the centre. Following an opening meeting, the inspector walked through the centre, reviewed the premises and met with residents and staff. Many residents were seen to be up and dressed, with some in the dining room for breakfast, and others getting assistance by staff in their bedrooms.

The centre is registered for 50 residents with 45 residents residing in the centre on the day of the inspection. Aisling House is a single storey building with communal areas accessible to residents comprising of three sitting rooms, two dining rooms, and a day room. There was beautiful sea views from some of these communal areas.

Bedroom accommodation comprised 34 single and eight twin-bedded bedrooms. Residents had access to en-suites and shared shower or bath facilities. A number of residents' bedrooms were viewed and were seen to have been personalised with family photos, plants and other personal items. Residents said they were happy with their bedrooms.

There was information on display for residents to include services such as advocacy and the Ombudsman. There was an activity schedule which outlined a number of activities available, however this was dated September 2025. The provider was in the process for recruiting an activity coordinator and at the time of the inspection, a healthcare assistant was assisting with activities. On the day of the inspection, a chair exercise class was held in the afternoon with good attendance. Residents' records reviewed showed residents were regularly attending activities such as music therapy, board games, nail painting and games such as skittles and bowls.

The centre was clean on the day of the inspection. However, there was noticeable wear and tear to some areas of paint work, and poor storage was observed including a discharged residents belongings stored in a day room. There was also inappropriate storage in the plant room creating a potential fire risk. Management were required to take immediate action to clear this area.

Overall, on the day of inspection the atmosphere in the centre was calm and relaxed. The inspector observed staff and residents' interactions, which were found

to be person-centred, kind and respectful. Visitors were seen coming and going during the day and those spoken to said they were made to feel welcome and were happy with the care their loved ones received within the centre. The inspector was told that there were no open complaints at the time of the inspection and residents spoken with confirmed they had no complaints, "everything is A1".

The inspector observed the lunchtime meal. The daily menu displayed different meal choices than those available on the day. The inspector was told this was an administrative error and the inspector observed residents were asked their choice by staff. On the day of the inspection, there was a choice of salmon or beef pie. Dessert options included apple tart or jelly and ice-cream. Meals were pleasantly presented and looked appetising. There were enough staff on duty to support residents at meal times, and residents were not rushed. Residents were complimentary regarding the meals in the centre with comments such as "the food is lovely".

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

Capacity and capability

Overall there were good governance and management arrangements in place to support the provision of a quality service for residents. Notwithstanding this, some areas did not fully meet the regulations, including in relation to records, documentation to renew the centre's registration, and governance and management.

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). This inspection also followed up on the compliance plan from the last inspection, reviewed solicited information, and was used to inform the upcoming renewal of registration for the designated centre.

Hussein and Jeanette Ali Limited is the registered provider for Aisling House Nursing Home. There are three company directors who are all involved within the management of the designated centre, two of these directors were present during this inspection and provided support to the person in charge.

The person in charge facilitated the inspection and was supported in their role by two senior nurses. Additional staff available included staff nurses, healthcare assistants, catering, housekeeping, laundry and maintenance. The inspector was told of one whole time equivalent (WTE) activity coordinator and two WTE healthcare assistant staff vacancies, with active recruitment ongoing for these posts. These vacancies were being covered through the provider's own staffing resources.

On the day of the inspection, there was sufficient staff available to attend to residents' needs.

The registered provider had a staff training and development policy, dated January 2026. Staff had access to a suite of training and there was high compliance in all areas such as fire training, manual handling, infection control and safeguarding. There was upcoming training scheduled on areas such as palliative care and basic life-saving skills.

The registered provider applied to the Chief Inspector of Social Services to renew the designated centre's registration in accordance with the requirements in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015. The registered provider had updated the statement of purpose and floor plans during this application. However, both documents did not fully accurately reflect the facilities, staffing levels and management structure provided within the designated centre.

Records were maintained in the centre in a secure but easily accessible format, including the statement of purpose and policies and procedures. However, some documents required under Schedule 2 and 4 were not available and this is further discussed under Regulation 21: Records.

There were some effective governance arrangements in the centre. Regular clinical governance meetings were occurring where key indicators including risks relating to falls, wounds, infections and malnutrition were discussed and tracked. The annual review of the service for 2025 had been completed and there was an action plan in place for 2026. Notwithstanding these good findings, the inspector found that issues were not always identified by the providers' internal monitoring system or ensure that they were actioned in a timely manner, indicating gaps in the oversight of the monitoring systems. This is further discussed under Regulation 23: Governance and Management.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider's application to renew registration was received within the correct timeframe and was under review at the time of the inspection.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the staff numbers and skill-mix were sufficient to meet the assessed needs of the 45 residents on the day of inspection. Rosters evidenced that there was a minimum of two staff nurses on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix and found that staff were facilitated to access mandatory training as required by the regulations. There was appropriate arrangements for supervision.

Judgment: Compliant

Regulation 21: Records

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

- Staff rosters were not maintained in line with the requirements of Schedule 4. For example, they did not record the hours worked for all members of management.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that it reflected all requirements as per Schedule 1. For example:

- the organisational structure for the registered provider included staff not employed by the registered provider
- the whole-time equivalent for all management and staff posts for the designated centre as listed on the statement of purpose did not match the staff rosters provided on the day of the inspection.

Judgment: Substantially compliant

Regulation 30: Volunteers

There were no volunteers working in the centre on the day of the inspection.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations. These policies had been reviewed at intervals not exceeding three years.

Judgment: Compliant

Regulation 23: Governance and management

Some of the management systems in place did not ensure adequate oversight in all areas such as documentation and the premises, to ensure that the service was safe and consistent. This was evidenced by:

- A sample of four staff files were reviewed by the inspector. While all records reviewed had garda vetting in place, one staff member did not have this vetting disclosure in place prior to commencing employment.
- While weekly weights were being taken, the inspector found that the assessment was not always updated at the same time. This lead to two resident's having incorrect MUST scores on the day of the inspection. This meant that care plans were not reviewed in response to the resident's changing need.
- Storage of flammable items in a high risk area which had not been identified within the oversight systems. It is acknowledged this was cleared on the day of the inspection.
- The registered provider had commissioned a fire safety risk assessment in October 2022, which was due for review in November 2023, this had not yet occurred.

There was an annual review for 2025 available, which referenced a new resident satisfaction survey was due to be actioned in 2026. However, the registered provider had not ensured that this review was prepared in consultation with residents and their families as required by the regulations.

Judgment: Substantially compliant

Quality and safety

The inspector observed person-centred and kind engagement between staff and residents throughout the inspection. Residents who could express a view were satisfied with the care they received.

There was a laundry on-site to launder bed linen and towels. Residents' clothing was laundered off-site by an external provider. Residents spoken with said they were happy with the laundry service received in the centre.

The premises was generally laid out to meet the residents' individual and collective needs. It was observed to be clean and efforts to maintain a homely environment were observed, however storage practices and wear and tear did not fully align with the requirements of Schedule 6 of the regulations.

Residents had access to fresh drinking water, and drinks were provided at regular intervals throughout the day. There was a choice of nutritious meals available, and sufficient staff to assist at meal times. Residents' weights were closely monitored and there was evidence of timely referral and assessment of residents by the dietitian. However, there was some discrepancies seen in the weight records for residents and their nutritional assessments as reported earlier within this report.

Residents had personal evacuation plans which contained details of residents' individual requirements. There was signage on display in bedrooms to alert staff to these evacuation requirements. Records were available for the maintenance of fire safety equipment to include fire extinguishers, emergency lighting and the fire alarm. The provider also had systems to review fire doors.

Regulation 12: Personal possessions

Residents were supported in accessing and retaining control over their personal property and possessions. The provider did not act as a pension agent. The provider did hold quantities of residents' money in safekeeping onsite and following a review of records, the inspector found there were safe systems in place for this.

Residents had sufficient space to store and maintain their clothing and possessions. Residents had access to lockable storage facilities in their bedrooms for valuables.

Judgment: Compliant

Regulation 17: Premises

The floor plans submitted as part of the provider's application to renew their registration did not correctly align with the foot print of the designated centre. For example, an area was referred to as a tea station on the floor plans which was in use as a storage area.

There were areas of the building that did not meet the requirements under Schedule 6 of the regulations. For example;

- There was unsuitable storage. This was evidenced by residents' equipment such as rollators, wheelchairs and clothing being stored in a communal area.
- There was some areas of wear and tear. For example:
    - the light-fitting in a number of twin-bedrooms did not fit correctly
    - some residents equipment was rusted such as a grab-rail on a resident's bed
    - paint work was damaged.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' weights were monitored on a regular basis in accordance with residents needs. The inspector observed there was adequate staff to support and assist people with their meals and refreshments. All residents spoken with said they enjoyed their meals.

Judgment: Compliant

Regulation 27: Infection control

The compliance plan from the last inspection was seen to be completed with evidence of water safety testing occurring.

Judgment: Compliant

Regulation 28: Fire precautions

Notwithstanding the good fire safety measures in place such as; equipment servicing records, fire safety training and regular participation in compartment fire drills. The limitations to fire precautions and oversight measures is discussed under Regulation 23: Governance and Management.
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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant

Compliance Plan for Aisling House Nursing Home OSV-0000003

Inspection ID: MON-0046021

Date of inspection: 24/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff rosters have been reviewed and updated to ensure compliance with Schedule 4 requirements, including the recording of hours worked for all members of management. The Operations Manager has been incorporated into the roster with defined working hours, and a standardised roster template has been implemented to ensure all staff, including management, have clearly recorded start and finish times. Ongoing oversight will be maintained through regular review of rosters by the Person in Charge to ensure continued compliance with record-keeping requirements. Date completed: 17/04/2026	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Statement of Purpose and associated floor plans have been fully reviewed and updated to ensure compliance with Schedule 1 requirements. The organisational structure has been amended to remove all references to external or contracted services, ensuring that it reflects only staff directly employed by the registered provider. In addition, a full review of the WTE table has been completed to ensure alignment with current staffing levels and rosters, and the Activities Coordinator role has been accurately reflected within both the WTE table and organisational chart. Ongoing review of the Statement of Purpose will be carried out annually and following any operational changes to ensure continued accuracy and compliance.	

Date completed: 30/03/2026	
Regulation 23: Governance and management	Substantially Compliant

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

A number of actions have been taken to strengthen governance and oversight systems within the centre. All staff files have been reviewed and Garda vetting disclosures are now in place, and a pre-employment compliance checklist has been introduced to ensure that all required documentation, including Garda vetting, is completed prior to any staff member commencing employment. Recruitment procedures have been updated and communicated to all relevant personnel, and ongoing compliance will be monitored through periodic staff file audits.

All MUST assessments have been reviewed and corrected to reflect current resident weights. Nursing staff have been reminded of the requirement to update MUST scores and associated care plans in response to any significant change in a resident's weight or nutritional status, rather than relying solely on scheduled review intervals. The current system of routine two-weekly review remains in place via the centre's electronic care planning system; however, this is now supported by a trigger-based review approach. A weekly audit has been introduced to cross-check residents' weights against MUST scores and care plans to ensure accuracy and timely updates.

Immediate action was taken on the day of inspection to remove inappropriate storage of flammable materials from the plant room. Storage practices across the centre have since been reviewed, with designated storage areas identified and communicated to staff. Weekly environmental checks have been introduced to ensure appropriate storage practices are maintained.

An updated Fire Risk Assessment was completed on 12 March 2026 by a competent fire safety consultant, with the final report received on 23 March 2026. A review of the report has been undertaken and an action plan developed to address all identified items. All high-priority actions are being progressed within defined timeframes, with remaining actions scheduled in line with risk categorisation. Fire safety oversight has been strengthened through inclusion in the centre's audit schedule and review at monthly governance meetings.

The annual review process has been updated to include consultation with residents and their families. Feedback mechanisms, including resident and family surveys and meetings, have been introduced, and the annual review template has been revised to ensure consultation is evidenced going forward.

Date to be completed: 30/04/2026
(Fire Risk Assessment actions to be completed by 23/09/2026)

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The floor plans submitted as part of the registration renewal process have been reviewed and updated to accurately reflect the current use of all areas within the centre. The Statement of Purpose has been updated accordingly to ensure full alignment between documentation and the physical environment.

Inappropriate storage identified during inspection has been addressed, with items removed from communal areas and storage areas reviewed and reorganised. Staff have been instructed on appropriate storage practices, and ongoing compliance will be monitored through regular environmental checks.

A maintenance review has been completed to identify areas of wear and tear, including paintwork, light fittings and equipment requiring repair or replacement. A repair schedule has been implemented, and works are currently in progress. Ongoing maintenance requirements will be monitored through weekly environmental checks and tracked to completion.

Date to be completed: 31/05/2026

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(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	31/05/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/05/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a	Substantially Compliant	Yellow	17/04/2026

	designated centre and are available for inspection by the Chief Inspector.			
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.	Substantially Compliant	Yellow	23/09/2026
Regulation 23(1)(f)	The registered provider shall ensure that the review referred to in subparagraph (e) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	30/04/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/03/2026