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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	19 August 2026
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0051023

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

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
Wednesday 19 August 2026	10:00hrs to 17:40hrs	Sean Ryan	Lead
Wednesday 19 August 2026	10:00hrs to 17:40hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in An Teaghlach Uilinn Nursing Home told the inspectors that they felt safe living in the centre. Residents reported that staff were kind and treated them respectfully. However, they expressed concern about the ongoing changes to staffing and management, and that they were unfamiliar with some staff, impacting on their sense of comfort in the centre.

Inspectors were met by the person in charge on arrival at the centre. Following an introductory meeting, the inspectors walked through the premises and met with residents and staff.

On the morning of the inspection, the atmosphere was busy. Staff were observed attending to residents' requests for assistance, while also answering call bells, and assisting residents with their breakfast in their bedrooms. Some residents were observed walking through the corridors independently, while other residents were observed in the communal dayrooms chatting to one another about local news and events. Residents acknowledged that staff were busy but also said they remained attentive to their needs. Residents were concerned that familiar staff had left and said that, although newly-appointed staff were kind, it would take time to build relationships with them. The also expressed concern about the extent of changes across all departments, including management, and the loss of established relationships with those they could approach for support. Residents told inspectors that they had raised their concerns at resident forum meetings but had not received a satisfactory response.

The premises was generally clean, comfortable and well-maintained. However, inspectors observed deterioration to wall finishes in one ground-floor wing, including exposed plaster and bubbling pain in corridors, communal areas and residents' bedrooms. Newly installed clinical hand-wash sinks were located close to areas where care was delivered and were observed to be frequently used by staff.

Throughout the day, residents were engaged in group and one-to-one activities led by the activities coordinator. Staff were also observed supporting residents to participate in activities. Residents were very complimentary about the activities provided.

The following sections of this report detail the findings with regard to the capacity and capability of the provider and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced risk inspection was carried out over one day by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended). Inspectors also reviewed the provider's progress in complying with a restrictive condition attached to the centre's registration, which required a stable and effective governance and management structure and improved compliance with the regulations to ensure the care, welfare and safety of residents.

Previous inspections of the centre had identified significant and repeated non-compliance with the regulations, particularly in relation to governance and management. The lack of effective governance and oversight had impacted on the quality and safety of care provided to residents and resulted in sustained non-compliance in key regulations that underpin the delivery of safe and quality care. As a result of these ongoing concerns, the Chief Inspector renewed the registration of the centre with a restrictive condition requiring the registered provider to establish a stable and effective management structure and improved regulatory compliance by 30 June 2026. A further inspection in July 2026, which focused on safeguarding and protection of residents, found that the provider had continued to fail to comply with the regulations. These concerns were compounded by the absence of a person in charge. Consequently, the Chief Inspector issued a notice of proposed decision to attach a further restrictive condition to the centre's registration, requiring resident admissions to cease until a stable and effective governance and management structure, including a person in charge, was in place.

The findings of this inspection were that the registered provider had failed to comply with a condition of registration attached to the centre's registration. A stable and effective management structure had not been established, and the required improvement in compliance with the regulations had not been achieved. This was compounded by changes to the management structure and personnel in key roles, both at senior management level and within the centre. This impacted on clear lines of accountability and responsibility, and on the registered provider's oversight of the service. Consequently, there had been a deterioration in compliance with the regulations, and the resulting governance and management failings were impacting on the quality and safety of care provided to residents.

Knegare Nursing Home Holdings Limited is the registered provider of this designated centre. It is a company comprised of five directors, one of whom represents the registered provider. On the day of this inspection, none of the directors were available to meet with or speak with inspectors.

Since the inspection in July 2026, further significant changes had occurred within the management structure of the designated centre. A number of management personnel had left their roles, and the centre had operated without a person in charge from June 2026 to August 2026, when the registered provider notified the Chief Inspector of a new person in charge. A new assistant director of nursing had also been appointed. The newly appointed person in charge was a senior manager

who had previously held responsibility for the clinical oversight of the service, but had now assumed responsibility for the day-to-day governance, operational management and administration of the designated centre.

At the time of this inspection, lines of accountability and responsibility within the nurse management structure were being established. The person in charge was reviewing the roles and responsibilities of the nurse management team and assigning defined areas of responsibility, with reporting arrangements to support their overall oversight of the centre. However, the registered provider had not considered the impact of the recent changes to the senior management structure on its oversight of the service. Arrangements had not been put in place to maintain senior-level clinical oversight or to ensure that clinical risks and concerns were appropriately escalated to the provider. The impact of these deficits were evident in the oversight and management of risk, incidents and the quality of care provided to residents.

Management oversight of the care and health care provided to residents was not effective. Inspectors found that care was not consistently delivered in accordance with residents' assessed needs and care plans, particularly for residents with complex supervision needs and those at risk of impaired skin integrity. Recommendations from health care professionals were not consistently implemented or followed-up, and clinical indicators that residents may require increased monitoring of their health needs were not appropriately identified, escalated or responded to. Consequently, the system of clinical oversight was not effective to ensure that residents' changing needs were appropriately monitored and managed.

The systems in place to monitor the delivery of the service was ineffective. There was an electronic system of auditing in use in the centre. A schedule of clinical and environmental audits was in place. Audits had been completed, however, there was minimal quality improvement actions planned or implemented following these audits. As a result, subsequent audits reflected that the standard of the service was deteriorating. This was not identified by the senior management of the service.

Risk management systems were not effective. While a risk register contained a range of clinical, operational and organisational risks, it did not include all risks with the potential to impact on the quality and safety of the service. In particular, significant changes to the management structure, both within the centre and at senior management level, had not been identified or assessed as risks. Consequently, effective controls had not been established before these changes occurred and this was found to impact on the oversight of the service.

The system in place to manage and respond to incidents involving residents was not effective. A review of incident records found that, while incidents such as unexplained injuries were documented, they were not appropriately reviewed or investigated to identify all potential contributing factors. While the incident-management arrangements included senior management oversight, this oversight had not identified that incidents were not being comprehensively screened for

potential safeguarding implications that may have required further action to protect residents.

Similar deficits were identified in the complaints process, where arrangements for the receipt, investigation and management of complaints were not fully effective. While some complaints were documented, they were not appropriately investigated in accordance with the centre's complaints procedure. In addition, complaints raised during residents' meetings were not recognised as complaints and, consequently, were not documented, investigated or managed through the established complaints process.

The management of records did not meet the requirements of the regulations. Staff rosters did not accurately reflect the management personnel working in the centre, records of nursing care provided to residents were not appropriately maintained, and records relating to investigations and complaints were incomplete. The repeated nature of these findings reflected a lack of management oversight and a failure to implement compliance plans to bring the centre into compliance with the requirements of the regulations.

On the day of inspection, there was a sufficient number of staff with the appropriate skill-mix to meet the assessed needs of residents. The rosters reviewed identified a high level of unplanned staff leave. However, resources were effectively managed to cover absences.

Staff were facilitated to attend training, and there was evidence that some staff had completed updated safeguarding training following the previous inspection. However, the arrangements for the supervision of staff were not effective. Changes within the nurse management structure impacted on the continuity and effectiveness of staff supervision. This was reflected in deficits in the monitoring of some residents health care needs, following up and implementing recommendations from health care professionals, and ensuring that specific care interventions were implemented for residents.

Regulation 15: Staffing

There was adequate staff available to meet the needs of the current residents, taking into consideration the size and layout of the building. There were satisfactory levels of health care staff on duty to support nursing staff. The staffing compliment included cleaning, catering, activities and administration staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of residents. This was evidenced by;

- poor supervision and oversight of the delivery of care and the implementation of recommendations of allied health care professionals.
- lack of oversight of the residents' clinical documentation to ensure the assessment and care planning were accurate and up-to-date.
- poor supervision of staff to ensure residents received care and support in line with their assessed needs.

Judgment: Not 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;

- Records of incidents and the investigation of the incidents in which residents may have suffered potential abuse or harm were not documented in line with the centre's own policy, as required by Schedule 3 (4)(j) of the regulations. There was incomplete documentation of investigations into incidents of unexplained bruising sustained by residents.
- Staff rosters were not maintained in line with the requirements of Schedule 4(9). Rosters did not reflect the names of the senior management personnel who attended and supported the designated centre.
- Clinical records were not maintained in line with professional requirements. Daily progress notes were not signed in line with professional guidelines.

Judgment: Not compliant

Regulation 23: Governance and management

Following changes to the management structure, lines of accountability and responsibility were not clearly defined. It could not be established who, within the senior management structure, held responsibility for the clinical oversight of the centre. In addition, pathways for escalating clinical and operational risks to the registered provider were not set out. This impacted on the registered providers oversight of the service.

Inspectors found that the management systems were ineffective to ensure a safe,monitored and consistent service was provided. This was evidenced by;

- ineffective systems of communicating key clinical information regarding residents changing health care needs. Changes in residents care needs and

recommendations made by health care professionals were not consistently communicated or acted upon. This posed a risk ro residents' care and welfare and impacted on the quality and continuity of care provided.
- poor oversight of the centre's complaints management system, and escalation of complaints, to ensure complaints were managed in line with the requirements of the regulations.This impacted on opportunities for learning and improving the service.
- risk management systems were not effectively implemented to identify, assess and manage risks within the centre. Significant changes to the management structure had not been appropriately assessed to determine their potential impact on governance, oversight and continuity of the service, and the necessary controls had not been established. In addition, risks associated with identified deterioration in the premises had not been assessed or managed.
- ineffective systems of monitoring in place. For example, an audit of the records pertaining to resident safety checks had been completed in June 2026. This audit identified significant gaps in these records. The was no appropriate action plan developed to address this issue. A repeated audit in July 2026 found a further deterioration in this area of record management. A review of the records of resident safety checks found that they remained incomplete at the time of the inspection.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors received information consistent with complaints relating to the staff and management resources in the centre. While residents confirmed that these concerns had been raised with senior management, and management confirmed that the residents had raised these issues, there was no documented evidence that the complaints had been recorded or managed, in line with the requirements of the regulations.

Judgment: Not compliant

Quality and safety

Inspectors observed that the interactions between residents and staff were kind and respectful, and staff were attentive to residents' needs. However, the quality and

safety of care was compromised by ineffective systems of governance and management, and insufficient management oversight and supervision of care. The registered provider had not implemented effective quality assurance and clinical oversight systems. The impact of these deficits was evident in the quality of residents' assessments and care plans, the management of their health care needs, the protection of their rights, and the arrangements for their safeguarding and protection.

All residents had an individual care plan in place, which was informed by assessments of their needs in areas such as mobility, nutrition and the risk of impaired skin integrity. However, care plans were not consistently underpinned by a comprehensive and accurate assessments, particularly in relation to residents' nutritional care needs. Consequently, staff did not have accurate and up-to-date guidance on the care interventions required to appropriately manage residents' assessed needs.

Residents had access to a general practitioner (GP) as required or requested, and GP's visited the centre to review residents health care needs. Arrangements were also in place to refer residents for specialist assessment by dietetic, physiotherapy and occupational therapy services. However, recommendations made by health care professionals were not consistently followed up or implemented, and the clinical monitoring of some residents was not carried out in accordance with best-practice guidance.

A safeguarding policy and procedure was in place to guide safeguarding practices within the centre. Staff had completed safeguarding training and understood their responsibility to report and escalate concerns regarding residents' safety and suspected abuse. The registered provider had also taken action to establish and implement arrangements to support residents to manage and access their personal finances. However, the registered provider had not taken all reasonable measures to protect residents from potential abuse. In particular, unexplained injuries were not appropriately investigated to determine whether there were any safeguarding implications or whether further protective action was required.

The registered provider had continued with a programme of redecoration within the centre, and the majority of areas were observed to be well-maintained. However, extensive deterioration to wall finishes was evident throughout one ground-floor wing, including corridors, communal areas and residents' bedrooms. Paint had been removed from lower sections of walls, leaving plaster exposed, while paintwork in other areas was bubbling. Inspectors were informed that this deterioration was associated with moisture. However, there was no plan in place to fully investigate the cause of complete the necessary remedial works.

Residents' social care needs were met to a satisfactory standard, and residents expressed satisfaction with the quality of activities and access to religious services within the centre. However, residents were dissatisfied with how they were consulted and supported to participate in the organisation of the service and in

decisions that affect them, particularly in relation to significant changes to the management structure.

Regulation 17: Premises

The registered provider had not ensured that all areas of the premises conformed to the requirements of Schedule 6 of the regulations.

Extensive deterioration to wall finishes was evident in corridors, communal areas and residents' bedrooms within the Holly unit. There was no time-bound plan in place to address this deterioration, and no assessment had been completed to identity and manage any potential risk to residents arising from the condition of the walls.

There continued to be a lack of facilities on the first-floor of the premises to support effective infection and control. There was no bedpan washer on the first-floor which meant that staff were required to bring utensils to the ground-floor sluice facilities to decontaminate them.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that they were not compliant with regulatory requirements. For example:

- Care plans were not consistently reviewed or updated in a timely manner following changes to a resident's condition or care needs. For example, some residents who had experienced weight-loss did not have an accurate assessment of their weight completed or an appropriate nutritional care plan developed to manage their nutritional care needs.
- A resident with a pressure-related injury did not have an appropriate care plan in place to guide staff on the management of the wound. Consequently, staff did not have clear and consistent guidance on the wound care required.
- Care was not consistently delivered in accordance with the residents' assessed needs and care plans. Residents with complex supervision needs did not receive the level and frequency of supervision and safety checks set out in their care plans. Similarly, planned repositioning was not carried out for residents at risk of pressure-related injuries.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

Residents were not always provided with appropriate medical and health care including a high standard of evidenced-based nursing care, in accordance with professional guidance. For example;

- A resident was not referred for timely medical review when clinically indicated. Records identified blood-glucose reading above the expected range. However, there was no documented evidence that these findings had been escalated for further review.
- Recommendations made by health care professionals were not consistently implemented. For example, blood monitoring, recommended in December 2025, for a resident with a complex medical condition had not been carried out.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had not taken all reasonable measures to protect residents from the risk of abuse.

Potential allegation of abuse and incidents that may have indicated potential abuse were not appropriately or comprehensively investigated to establish the circumstances, nor did they identify any safeguarding implication to determine whether further protective action was required, including staff training.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had not ensured that residents were adequately consulted or supported to participate in the organisation of the service. Residents reported that they had not been sufficiently consulted about changes affecting the operation of the service and did not feel that the concerns they raised were being listened to or addressed.

Judgment: Not 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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0051023

Date of inspection: 19/08/2026

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	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

The person in charge has reviewed the nurse management structure and has assigned each member of the nurse management team (ADON and CNMs) defined areas of responsibility, including the units and staff for which they hold supervisory responsibility. These responsibilities are documented in writing and have been communicated to all staff, so that every staff member knows who supervises their work on each shift and who they report to.

On each shift, the nurse in charge is responsible for the direct supervision of the nursing and health care staff delivering care on that shift. This includes allocating staff to residents, ensuring that residents requiring enhanced supervision, safety checks, repositioning or specific nutritional interventions are identified at handover, checking during the shift that these interventions are being delivered and recorded, and addressing any omission before the end of the shift. Any omission that cannot be resolved on the shift is escalated to the CNM/ADON.

The ADON/CNM will complete a daily clinical walk-round of each unit to observe the care being delivered, review residents whose condition has changed, and confirm that recommendations made by GPs and allied health care professionals have been actioned. A tracker of all allied health care professional recommendations is maintained, identifying the resident, the recommendation, the nurse responsible and the date completed. This tracker is reviewed at the daily nurse management meeting so that no recommendation remains outstanding without a documented reason and follow-up.

Supervision of clinical documentation has been strengthened. The CNM/ADON will review the assessments, care plans and progress notes of a sample of residents on each unit every week, with priority given to residents who have had a change in condition, weight loss, a wound, an incident or a hospital transfer. Inaccurate or out-of-date documentation identified on review will be corrected by the responsible nurse and the

review recorded.

Formal, documented appraisal meetings will be held with each nurse and health care assistant by their line manager. These will address the standard of care delivered, care planning and documentation, escalation of clinical concerns and any learning arising from audits, incidents or complaints. An appraisal schedule and record will be maintained by the person in charge. Where a performance concern is identified, it will be addressed through individual supervision, competency assessment and, where necessary, the centre's performance management process.

Competency assessments will be completed for nursing and health care staff in the areas identified during the inspection, including wound care, nutritional assessment and weight monitoring, repositioning, safety checks and the recognition and escalation of clinical deterioration.

The nurse management team will be supervised by the person in charge through weekly nurse management meetings at which the supervision of staff, outstanding recommendations, audit findings and documentation reviews are discussed and actions assigned. The person in charge will in turn report on supervision arrangements to the provider through the monthly governance meeting.

Compliance with these supervision arrangements will be monitored through audits of care delivery records, care plans and supervision records, and the findings will be reviewed through the centre's quality and safety processes. The registered provider will maintain oversight to ensure that effective supervision is sustained irrespective of changes in management personnel.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

All incidents of unexplained bruising or injury and any incident with potential safeguarding implications recorded since the previous inspection have been reviewed by the person in charge. Where the investigation record was incomplete, the investigation has been completed and documented in so far as the available information allows, and any outstanding safeguarding considerations or protective measures have been actioned. A standard incident investigation record has been introduced which requires documentation of the circumstances of the incident, the accounts obtained from the resident, staff and any witnesses, the records reviewed, the findings, whether safeguarding implications were identified, the actions taken, the outcome and the sign-off of the person in charge. All incidents will be investigated and recorded on this

template in line with the centre's incident management and safeguarding policies, and the person in charge will review and sign off each investigation record before the incident is closed.

The roster has been revised to record all persons working in the centre, including the person in charge, the ADON, the CNMs and any senior management or head office personnel attending the centre to provide governance or clinical oversight support. Each entry identifies the person's name, role and the hours worked. The planned roster and the actual hours worked are both maintained, and any changes to the planned roster are recorded so that the roster accurately reflects who was on duty on any given day. The person in charge will review and sign off the roster each week to confirm that it is accurate and complete.

Agency Nursing Staff have been reminded of their professional obligation under the NMBI guidance on recording clinical practice to ensure that every entry in a resident's clinical record is signed, dated and timed and identifies the name and designation of the person making the entry. Daily progress notes will be checked by the nurse in charge at the end of each shift to confirm that entries are complete and signed, and a weekly spot check will be carried out by the CNM/ADON. Any unsigned or incomplete entries will be addressed with the individual agency member through supervision.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider is reviewing the management structure for the centre. The structure will set out the provider representative, the senior management roles supporting the centre, the person in charge, the ADON and the CNMs, together with the lines of authority and accountability between them and the areas of care provision for which each role is responsible. The structure will clearly identify the senior management role that holds responsibility for the clinical oversight of the centre and the role to which the person in charge reports. The updated structure will be communicated to staff and will be notified to the Chief Inspectors.

In relation to communicating key clinical information, a structured nursing handover is completed at each shift change and a daily nurse management meeting is held to review residents whose condition has changed, outstanding GP and allied health care professional recommendations and any missed care interventions. A tracker of all health care professional recommendations is maintained and reviewed daily by the CNM/ADON so that each recommendation is assigned to a named nurse, actioned within the

recommended timeframe and recorded in the resident's care plan.

The person in charge reviews the complaints register weekly to confirm that all complaints, including those raised verbally or at residents' meetings, have been recorded, investigated and responded to in line with the centre's complaints procedure. Complaints, their outcomes and any learning are reported to the provider through the monthly governance meeting, as set out in the response to Regulation 34.

The risk register has been reviewed and updated to include the risks arising from the changes to the management structure at centre and senior management level, the current staffing vacancies, and the deterioration to the premises in the Holly unit. Each risk has been assessed and has documented controls, a responsible person and a review date. The risk register is reviewed at the monthly governance meeting.

The audit schedule has been reviewed to ensure that every audit results in a documented quality improvement plan identifying the deficits found, the actions required, the person responsible and the completion date, and that the audit is repeated to confirm the actions have been effective. The audit of resident safety check records has been repeated and an action plan implemented, which includes residents requiring safety checks being identified at every handover, the nurse in charge confirming during each shift that checks are completed and recorded, and a daily review of the records by the CNM/ADON. This audit will be repeated weekly until compliance is sustained and monthly thereafter.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Following the inspection findings, the registered provider reviewed the complaints management process to ensure that all complaints, including verbal complaints and expressions of dissatisfaction raised by residents or their representatives, are recognised, documented and managed in accordance with the centre’s complaints procedure.

The concerns identified during the inspection in relation to staff and management resources have been retrospectively reviewed and recorded where sufficient information is available. Residents concerned have been followed up with to establish whether their concerns remain outstanding and to ensure that they are satisfied with the actions taken or that any outstanding matters are appropriately addressed.

Staff and management have been reminded that a concern does not need to be submitted in writing to constitute a complaint. Any verbal or written expression of

dissatisfaction requiring a response must be recorded on the centre's complaints system/register and managed through the complaints procedure.

All complaints will include a clear record of the concern raised, date received, acknowledgement, investigation/actions undertaken, communication with the complainant, outcome, learning identified and reason for closure. The complainant's satisfaction with the outcome will also be documented where this can be established. Residents and their representatives will continue to be informed of the complaints process and their right to raise concerns without fear of adverse consequences.

The PIC/complaints officer will review the complaints register regularly to ensure that complaints are acknowledged, investigated, responded to and closed within the required timeframe and that appropriate documentary evidence is maintained.

Complaints and trends will be reviewed through the centre's governance and quality and safety processes. Learning arising from complaints will be communicated to relevant staff and incorporated into service improvement actions where required.
Resident meetings will also be reviewed for concerns or expressions of dissatisfaction raised by residents. Where an issue meets the threshold of a complaint, it will be transferred to the complaints process and formally recorded, investigated and followed through to outcome and closure.

Monthly complaints audits will be completed by management to monitor compliance with the complaints procedure and Regulation 34 and to ensure that improvements are sustained.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A risk assessment of the condition of the walls in the corridors, communal areas and residents' bedrooms in the Holly unit has been completed by the person in charge and the facilities/maintenance lead. The assessment addresses the risk of injury from loose or damaged plaster, the risk of dust or debris, and infection prevention and control risks associated with damaged surfaces and moisture. Interim controls have been put in place, including the removal of any loose material, daily checks of the affected areas by the maintenance staff with any deterioration recorded and addressed, and enhanced cleaning of the affected areas. The risk has been added to the centre's risk register and will be reviewed monthly until the remedial works are complete.

A further specialist survey of the affected areas will be carried out to establish the source of the moisture causing the deterioration. The survey will be commissioned by 24th

September, and the report will be received by approximately two weeks.

On receipt of the survey report, a time-bound programme of remedial works will be agreed by the registered provider. The programme will address the cause of the moisture first, followed by the repair of the affected plaster and the redecoration of the affected areas. The works will be phased by area, with residents' bedrooms prioritised, and will be planned to minimise disruption to residents. Residents will be consulted about the timing of works affecting their bedrooms and communal areas. The programme, including the start and completion dates for each phase, will be documented and progress will be reviewed at the monthly governance meeting. It is anticipated the remedial works will be completed by 23rd December 2026.

Until the first-floor sluice facilities are in place, the following interim infection prevention and control measures apply: used bedpans, urinals and other utensils are transported to the ground-floor sluice in closed, covered containers by a designated route; staff adhere to hand hygiene and personal protective equipment requirements when handling used utensils; and compliance with these measures is monitored through the centre's infection prevention and control audits.

Regulation 5: Individual assessment and care plan	Not Compliant

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

A comprehensive review of all residents' assessments and care plans has been undertaken by the clinical management team. A further validation review is currently in progress to ensure that assessments and care plans accurately reflect residents' current clinical needs, identified risks and required interventions.
Particular focus has been placed on the areas identified during the inspection, including nutrition and weight loss, wound management, supervision and safety checks, and repositioning.

Residents who have experienced weight loss or changes in nutritional status have been reviewed to ensure that weights are accurate, MUST assessments are current and nutritional care plans clearly identify the interventions required. Where clinically indicated, residents are referred to the GP, dietitian or other appropriate healthcare professional. Weight trends are monitored, and any significant or unexplained weight loss is escalated and reflected in the resident's care plan.

Residents with wounds or pressure-related injuries have been reviewed to ensure that an appropriate wound assessment and individualised care plan are in place. Care plans provide clear guidance to staff regarding wound management, dressing requirements,

pressure-relieving measures, skin inspection, repositioning and escalation of deterioration. Wound management is subject to ongoing clinical review and audit.

Residents requiring enhanced supervision or scheduled safety/comfort checks have been reviewed. Care plans clearly specify the level and frequency of supervision required. Staff allocations and handovers identify residents requiring enhanced supervision to ensure that assessed interventions are implemented consistently and documented contemporaneously.

Residents assessed as requiring planned repositioning have been reviewed to ensure that the required frequency and interventions are clearly documented within their care plans. Repositioning records are monitored by the Nurse in Charge to ensure that planned care is delivered and recorded. Any missed intervention is followed up promptly and escalated to the PIC/clinical management team where required.

All residents' care plans have undergone review. Third-quarter care plan reviews were discussed with residents and/or their NOK/representatives, as appropriate. Quarterly reviews are currently ongoing.
Care plans are reviewed following any significant change in a resident's condition, identified risk, incident, hospital admission/return, weight or nutritional change, wound development or other change in care needs and are updated without delay where required.

In recognition that this is a repeated finding, additional monitoring arrangements have been implemented.

The PIC and clinical management team will undertake scheduled care plan audits, with focused audits on nutrition/weight management, wounds, supervision/safety checks and repositioning. Audit findings will identify the resident affected, specific deficit, required corrective action, responsible person and completion date.

Nurses in Charge will monitor the delivery and recording of high-risk care interventions during each shift, including required safety checks, enhanced supervision and repositioning. Identified omissions will be addressed on the shift and escalated through the clinical governance structure where necessary.

Findings and trends from audits, incidents, wounds, weight monitoring and missed care interventions will be reviewed through the centre's Quality and Safety/clinical governance meetings. Recurrent gaps will result in further corrective action, staff supervision and education as appropriate.

The registered provider will maintain oversight of these measures to ensure that improvements are embedded in practice and that residents receive care consistently in accordance with their assessed needs and individual care plans.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Following the inspection findings, the registered provider has reviewed the arrangements for clinical monitoring, escalation of abnormal findings and implementation of recommendations made by medical and other healthcare professionals.

The residents identified during the inspection have been reviewed by the clinical management team. Outstanding clinical monitoring and healthcare professional recommendations have been followed up and completed or referred for appropriate medical review, as clinically indicated.

Residents requiring blood glucose monitoring or other clinical observations have had their care plans reviewed to ensure that the required frequency of monitoring is clearly documented together with appropriate escalation guidance.
Nursing staff have been reminded that abnormal clinical findings, including blood glucose readings outside the resident's expected/individualised range, must be clinically assessed, documented and escalated to the GP/out-of-hours medical service or other appropriate healthcare professional where indicated. The action taken and outcome of the escalation must be clearly documented in the resident's clinical record.

A review of outstanding recommendations made by GPs and other healthcare professionals has been undertaken. Recommendations, including requested blood monitoring and investigations, are now tracked to ensure that they are implemented within the recommended timeframe.
Where a recommendation cannot be completed within the required timeframe, the reason will be documented and escalated to the PIC and relevant healthcare professional for further direction.

Residents with complex medical conditions have had their assessments and care plans reviewed to ensure that required clinical monitoring, individualised escalation parameters and healthcare professional recommendations are clearly reflected within their care plans.
Care plans will be updated following medical review, changes in clinical condition, abnormal clinical findings or new recommendations from healthcare professionals.

The PIC and clinical management team will monitor compliance through regular clinical documentation and care plan audits.

Clinical spot checks will include review of blood glucose monitoring and other required observations to ensure that abnormal results have been appropriately assessed, escalated and documented.
Any identified gaps will be addressed promptly with the individual staff member and, where required, through clinical supervision and further education. Findings and trends will be reviewed through the centre's clinical governance and Quality and Safety processes.

These actions will ensure that residents receive timely and appropriate medical and nursing care, abnormal clinical findings are appropriately escalated, and recommendations made by healthcare professionals are implemented and monitored through to completion.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Following the inspection findings, the registered provider has strengthened safeguarding arrangements to ensure that all allegations, suspected abuse and incidents that may have safeguarding implications are recognised, appropriately investigated and managed to protect residents from the risk of abuse.

A review of safeguarding concerns and relevant incidents has been undertaken by the PIC/management team to identify whether safeguarding implications were appropriately considered and whether adequate protective measures were implemented.
Where required, safeguarding plans and associated risk assessments have been reviewed and updated to clearly identify the risk, immediate protective measures, ongoing controls and guidance for staff.

All allegations or incidents with potential safeguarding implications will be subject to a comprehensive preliminary review/investigation to establish the circumstances surrounding the event. This will include, as appropriate, obtaining accounts from the resident and relevant staff/witnesses, reviewing clinical and care records, incident documentation, staff allocations and other relevant evidence.
The investigation will clearly document the findings, safeguarding implications, immediate and ongoing protective measures, outcome and any further actions required.
Where appropriate, safeguarding concerns will be notified/referred to the relevant external authorities in accordance with regulatory requirements and the centre's safeguarding procedures.

Staff have been reminded that safeguarding is not limited to confirmed allegations of abuse. Incidents, unexplained injuries, changes in resident behaviour, peer-to-peer incidents, allegations concerning care practices and other concerns that may indicate potential abuse must be reported immediately to the Nurse in Charge/PIC and assessed for safeguarding implications.
Immediate measures will be implemented where necessary to protect the resident while the concern is being reviewed.

Safeguarding education is being reinforced with staff, with particular emphasis on recognising potential abuse, immediate reporting, preservation of relevant information, documentation and implementation of protective measures.
Following safeguarding incidents or investigations, the PIC/management team will

identify whether individual or wider staff training, supervision or competency review is required. Learning identified will be communicated to relevant staff through supervision, staff meetings, handovers and safety pauses, as appropriate.

Safeguarding incidents, investigation outcomes, trends and learning will be reviewed through the centre's clinical governance and Quality and Safety processes. Any identified gaps will have a documented action, responsible person and completion date and will be monitored through to closure.

The strengthened safeguarding process will ensure that allegations and incidents with potential safeguarding implications are recognised, comprehensively investigated and appropriately managed, with effective protective measures implemented and learning used to reduce the risk of recurrence.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Following the inspection findings, the registered provider has strengthened arrangements to ensure that residents are meaningfully consulted and supported to participate in decisions regarding the organisation and operation of the designated centre.

The PIC and management team have reviewed the arrangements for resident consultation and engagement. Residents are being actively encouraged and supported to express their views, preferences and concerns regarding the operation of the service and changes that may affect their daily lives.
Regular resident meetings are being held, with residents provided with opportunities to raise concerns, make suggestions and provide feedback regarding the service. Minutes of meetings clearly document the issues raised, actions required, responsible person and follow-up undertaken.
Where a resident raises an individual concern or expression of dissatisfaction that constitutes a complaint, this is recorded and managed through the centre's complaints procedure rather than relying solely on documentation within resident meeting minutes.

Residents will be consulted, where appropriate, in advance of planned changes that may affect the organisation or delivery of the service.
Information will be provided in an accessible manner, and residents will be given an opportunity to ask questions, express their views and provide feedback.
Where decisions have been made following consultation, management will communicate the outcome to residents, including what action has been taken in response to their feedback or, where a requested change cannot be implemented, an explanation will be provided.

In addition to formal resident meetings, management will maintain regular engagement

with residents through individual discussions, management walkabouts and other appropriate consultation methods.
Residents will continue to be informed of their right to access independent advocacy services and will be supported to access advocacy where requested.

The PIC/management team will maintain oversight of resident consultation through regular review of resident meeting minutes, complaints, resident feedback and actions arising from consultation.
An action tracker will be maintained following resident meetings and consultation. Each action will identify the issue raised, action required, responsible person, target date and outcome. Actions will be followed through to completion and feedback provided to residents.
Resident satisfaction and feedback will also be reviewed periodically to establish whether residents feel listened to, involved and appropriately informed about matters affecting the service.

The strengthened consultation arrangements will ensure that residents are actively involved in the organisation of the service, appropriately consulted regarding changes that affect them, and provided with clear feedback regarding concerns and suggestions raised. Ongoing monitoring will provide assurance that residents' views are listened to, acted upon where appropriate and used to inform continuous improvement within the centre.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	16/10/2026
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	23/12/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	09/10/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management	Not Compliant	Orange	16/10/2026

	structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	16/10/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on 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.	Not Compliant	Orange	08/09/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs	Substantially Compliant	Yellow	01/09/2026

	of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/11/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/11/2026
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with	Substantially Compliant	Yellow	01/09/2026

	professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Substantially Compliant	Yellow	01/09/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	01/09/2026
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	01/09/2026
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	16/09/2026