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:	Bailey's Nursing Home
Name of provider:	Ougham House Limited
Address of centre:	Mountain Road, Tubbercurry, Sligo
Type of inspection:	Unannounced
Date of inspection:	10 March 2026
Centre ID:	OSV-0000316
Fieldwork ID:	MON-0047233

About the designated centre

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

Bailey's Nursing Home is registered to provide care for 43 residents. Twenty-four-hour nursing care is provided to dependent persons aged 18 years and over who require long-term residential care or who require short-term respite, convalescence, dementia or palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. Male and female residents are accommodated. It is located in a residential area, a few minutes' drive from the town of Tubbercurry in County Sligo. Residents' accommodation comprises 21 single and 11 twin-bedrooms. There is a variety of sitting areas where residents can spend time during the day, and a safe garden area where they can spend time outdoors. Other facilities include a visitors' room, laundry, kitchen, staff areas, offices, sluice facility and cleaning room. The laundry is located in an external building close to the centre. The centre is a family-run business that has operated since 1995. The objective of care, as described in the statement of purpose, is to encourage each resident to maintain their independence while offering all the necessary care and assistance.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	42

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 10 March 2026	09:00hrs to 15:00hrs	Fiona Cawley	Lead
Tuesday 10 March 2026	09:00hrs to 16:30hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Inspectors observed that residents living in this centre received a good standard of care and support. Residents were complimentary about the staff in the centre and the care they provided. Staff were observed to deliver care and support to residents which was respectful and in line with their assessed needs.

Bailey's Nursing Home is located on the outskirts of Tubbercurry, County Sligo. The centre was a two-storey, purpose-built facility which provided accommodation for 43 residents. This unannounced inspection took place over one day. There were 42 residents accommodated in the centre on the day of the inspection and one vacancy.

Inspectors arrived in the centre mid-morning. Following an introductory meeting with an assistant director of nursing, inspectors spent time walking through the centre, reviewing the living environment and meeting with residents and staff. A number of residents were having breakfast in the dining area and bedrooms, while other residents were relaxing in communal areas. A number of residents were being assisted and supported by staff with their personal care needs. Staff were observed assisting residents in an unhurried and caring manner. There was a relaxed and friendly atmosphere throughout the centre.

Residents' living and bedroom areas were located on the ground floor. There were a number of bright communal areas available to residents, including day rooms, a dining room and a quiet room. There was sufficient space available for residents to meet with friends and relatives in private should they wish to. All areas were appropriately styled and furnished to create a homely environment for residents. Many bedrooms were personalised and decorated according to each resident's individual preference. Corridors provided adequate space to accommodate residents with walking aids, and there were appropriate handrails available to assist residents to mobilise safely. There was a sufficient number of toilets and bathroom facilities available to residents. The centre was bright, warm, and well-ventilated throughout. Call-bells were available in all areas and answered in a timely manner. The centre was very clean and tidy.

Residents also had unrestricted access to an outdoor area which contained seasonal plants and suitable seating areas.

Overall, there was sufficient space for residents to live comfortably in many of the bedrooms including adequate space to store personal belongings. However, inspectors observed that a number of twin-occupancy bedrooms were small in size and presented challenges to the provision of adequate space. The size of each individual resident's space did not provide an area of 7.4 square metres of floor space to include space for a chair and personal storage for each resident. In addition, the layout of these twin bedrooms was not suitable to meet the needs of

the two residents residing in them, should they require support with their mobility. This will be discussed further under Regulation 17: Premises.

Throughout the day, inspectors spent time observing staff and resident interaction in the various areas of the centre. The majority of residents were up and about as the day progressed. Residents were observed to be content as they went about their daily lives. They were relaxed and familiar with one another and in their environment. Residents moved freely around the centre, and were observed to be socially engaged with each other and staff. Inspectors observed various activities taking place during the day of the inspection, including a game of bingo. Staff ensured that residents were facilitated to be as actively involved in activities as they wished. Staff supervised communal areas appropriately, and those residents who chose to remain in their rooms, or who were unable to join the communal areas, were monitored by staff throughout the day.

The dining experience at lunchtime was observed to be a relaxed occasion, and inspectors saw that the food was appetising and well presented. Residents were assisted by staff, where required, in a sensitive and discreet manner. Other residents were supported to enjoy their meals independently.

Residents were happy to chat with inspectors throughout the day, and to provide an insight into their experience of living in Bailey's Nursing Home. Residents said that they were happy with life in the centre, and that they felt safe and well-looked after. One resident described living in the centre as 'better than being at home', and another resident said, 'I have no complaints, when I need help I get it'.

Friends and families were facilitated to visit residents, and inspectors observed many visitors coming and going throughout the day. A number of visitors told inspectors that they were very satisfied with the care received by their loved one and that they could speak with management if they had any concerns.

In summary, inspectors found that residents received a good service from a responsive team of staff delivering safe and appropriate care and support to residents.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

This was an unannounced monitoring inspection carried out 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). This

inspection also had a specific focus on the provider's compliance with fire safety practices and oversight. Inspectors also followed up on the application to vary a restrictive condition on the registration of this centre submitted by the provider. Condition 4 of the registration of the centre required the provider to reduce the occupancy of 10-twin occupancy bedrooms by 31 January 2026.

The registered provider of this centre is Ougham House Limited, a company comprised of two directors. There was an established management structure in place, with clear lines of responsibility and accountability. There was a person in charge in post, supported by an assistant director of nursing (ADON) and a full complement of staff, including nursing and care staff, activity, housekeeping, administration and catering staff. Management support was provided by one of the directors of the company. There were systems in place to ensure appropriate deputising arrangements in the absence of the person in charge. On the day of the inspection, the person in charge was not available, and the assistant director of nursing, who was deputising in their absence, facilitated the inspection.

There were sufficient resources in place at the centre to ensure that the quality and safety of the services provided to residents were of a good standard. On the day of the inspection, staffing levels were appropriate for the size and layout of the centre and to meet the needs of the 42 residents being accommodated at the time. The team providing direct care to residents consisted of at least one registered nurse on duty at all times and a team of healthcare assistants. Inspectors observed that staff were appropriately supervised and supported to provide safe care to residents.

Training records demonstrated that staff had access to a varied training programme including infection control, managing responsive behaviours and safeguarding vulnerable adults. This training programme was ongoing at the time of the inspection.

Overall, inspectors found that some improvement actions had been implemented since the last inspection in October 2025, and acknowledged that the majority of actions committed to by the provider were in progress in line with the compliance plan submitted following the previous inspection. The provider had a number of management systems in place to monitor and review the quality of the service provided for the residents. There was a schedule of audits which evaluated practices, such as falls management, medication management, and provision of personal care. Where areas for improvement were identified, action plans were developed and completed. In addition, key aspects of the quality of the service were collected and reviewed by the person in charge on a monthly basis. However, inspectors found that some of the management systems were not robust and some of the known risks in the centre, identified on the previous inspection, had not been identified and therefore not appropriately addressed by the provider. For example, inspector found repeated evidence of non-compliance with Regulation 5: Individual assessment and care planning. Furthermore, records management, fire precautions and premises were found not to be in full compliance with the regulations.

A review of a sample of five staff files found that records were not in line with the requirements of Schedule 2. One staff record was incomplete, while two other files were not available for inspection.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider submitted an application to vary Condition 4 of the registration of the centre. The fee was paid, and the application was submitted in full.

Judgment: Compliant

Regulation 15: Staffing

The number and skill-mix of staff was appropriate with regard to the needs of the residents, and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to mandatory training, and staff had completed all necessary training appropriate to their role.

There was appropriate supervision of all grades of staff, and oversight of the standard of care they provided in place on the day of inspection.

Judgment: Compliant

Regulation 21: Records

The system in place to manage the records set out in Schedule 2 of the regulations did not facilitate effective record-keeping. For example;

- One staff file was complete and did not contain all the information required by the regulations, such as, evidence of a staff member's identity, full employment history or written references from their most recent employer.

- There were no staffing records available in the centre for two staff members.

Judgment: Substantially compliant

Regulation 23: Governance and management

In consideration of fire safety matters identified during the inspection, appropriate management systems were not in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored by the provider.

The oversight of fire safety in the centre was not robust, as it did not adequately support effective fire safety arrangements and keep residents safe. For example;

- Fire safety checks with regards to appropriate storage arrangements did not identify storage issues which impacted on fire safety, and resulted in an immediate action being issued to the provider.
- The providers' in-house fire management systems, such as audits and the fire register, had not identified fire risks in the centre and did not fully support the oversight of fire the centre. These are outlined in detail under Regulation 28: Fire Precautions.
- Recommended actions and learning from previous fire evacuation drills highlighted deficiencies in the evacuation strategy that posed a risk to residents in a fire emergency. Increased vigilance and a review of staffing supervision to areas beyond the evacuated compartment was recommended. This was in order to prevent unintentional ingress of residents from other areas during a compartment evacuation. This had not been actioned. This is outlined in detail under Regulation 28: Fire Precautions.

Furthermore, the management systems in place to ensure effective oversight of the service were not fully effective. For example:

- Inadequate oversight of nursing documentation, particularly in relation to care planning
- Inadequate oversight of records management, in particular, staff files.
- Inadequate oversight to ensure that residents' rights were promoted and upheld and that a person-centred environment was delivered to the residents, as evidenced under Regulation 9: Residents' rights.
- The provider did not ensure that the premises conform to matters set out under Schedule 6 of the Regulations, and in respect of the 10 twin-occupancy rooms, in line with the compliance plans submitted to the office of the Chief Inspector as outlined under Regulation 17: Premises.

Judgment: Not compliant

Quality and safety

This inspection found that the management and staff worked to provide a good quality of life for the residents living in the centre. Residents were satisfied with the service they received, and reported feeling safe and content living in the centre.

Care delivered to the residents was of a good standard, and clinical staff were knowledgeable about residents' care requirements. Inspectors reviewed a sample of four residents' care records. A range of clinical assessments was carried out for each resident on admission to the centre to identify care and support needs. The care plans reviewed were person-centred, holistic and contained the necessary information to guide care delivery. However, a number of care plans were not updated in line with the requirements of the regulation.

Residents were provided with access to appropriate medical care, with residents' general practitioners providing on-site reviews. Residents were also provided with access to other healthcare professionals, in line with their assessed needs.The provider promoted a restraint-free environment in the centre, in line with local and national policy. Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had appropriate assessments completed. Person-centred care plans were developed, detailing the supports and the interventions to be implemented by staff, to support a consistent approach to the care of the residents. Care plans included details of interventions to support the resident to manage responsive behaviours. Interactions observed between staff and residents were person-centred and non-restrictive.

Inspectors observed that residents' rights and choices were respected and promoted in the centre. Residents were free to exercise choice in their daily lives and routines. Residents could retire to bed and get up when they choose. Activities were observed to be provided by dedicated activities staff, with the support of health care staff. Residents attended regular meetings and contributed to the organisation of the service. Residents had access to an independent advocacy service.

The person in charge ensured that, where a hospital admission was required for any resident, transfers were safe and effective by providing all relevant information to the receiving clinicians and that all relevant information was obtained on the resident's return to the centre.

This inspection found that the management of fire safety did not fully ensure the safety of residents, staff and visitors. Inspectors found non-compliance with fire-containment, visual deficiencies in the building fabric and fire doors, inappropriate location of combustible and flammable material, emergency lighting and evacuation procedures. For example, flammable and combustible items were found beside a generator. This created a fire risk, and the storage of flammable items created a

potential fire source should a fire occur. These and other examples of fire risks are outlined in detail under Regulation 28: Fire Precautions.

Inspectors reviewed the fire safety register and noted that parts of it were well organised. In-house periodic fire safety checks were being completed and logged in the register as required. However, deficiencies identified during the inspection, such as inappropriate storage, deficiencies in the building fabric, emergency lighting and fire doors had not been identified in the in-house routine checks.

There was a fire safety management plan and an emergency fire action plan in place. Inspectors spoke with a number of staff who had good knowledge of the procedures required for evacuating residents, and the procedures to be followed in a fire emergency. However, fire drill records highlighted shortcomings and recommendations to be actioned. This is outlined under Regulation 28: Fire Precautions.

Residents' living environment was being maintained and was decorated in a traditional style that was familiar to them. However, improvements were required to the walls and ceiling surfaces that required sealing and redecoration to address gaps in these surfaces. While the layout of most of the residents' bedrooms met their needs, significant improvements continued to be required for the layout of 10 twin-occupancy bedrooms. The provider acknowledged this finding and had a plan in place to address the layout of these 10 twin bedrooms. However, this had yet to be carried out, and issues with the layout of the twin rooms persisted to impact on these residents.

Regulation 17: Premises

The layout and design of 10 twin bedrooms in the designated centre did not adequately meet the needs of residents in accordance with the centre's statement of purpose and residents' needs, as follows;

- The layout of ten twin bedrooms numbered 20 to 29, located along both sides of one corridor, did not meet residents' needs. These bedrooms varied in size from 14.8 to 14.9 square meters, and in a number of these bedrooms, the layout of the room did not facilitate each resident to rest in a chair by their bedside, or to access their bed without disturbing the resident in the other bed.
- One out of the two residents in these twin rooms was not afforded access to light when a privacy curtain is in use, as the only window in the room was in the bed space of the other resident.
- The size of each individual resident’s space did not provide an area of 7.4 square metres of floor space to include space for a chair and personal storage for each resident. The bed space sizes in the twin rooms varied in size from 4.3 and 6.5 square meters.

- In many of these twin bedrooms, one side of the inside bed, which was closest to the window, was placed close to the wall. A number of the residents in these bedrooms needed specialist equipment and two staff to support their personal care and transfer needs into and out of bed. The space available around and between the residents' beds in these rooms was not sufficient to facilitate the passage of assistive equipment to access the bed closest to the external wall without moving the other bed aside.
- As a consequence, the residents in the beds closest to the door were regularly disturbed to allow staff to use the assistive equipment that was needed for the second resident in these bedrooms. The findings are repeated from previous inspections.
- There was inadequate storage provided in ensuite facilities in twin bedrooms.
- Some rooms were not provided with adequate numbers of chairs.

Additionally, the provider did not ensure the premises complied with the requirements of Schedule 6 of the regulations, especially in some areas of the premises that required maintenance attention internally. For example:

- A handrail was noted to be broken in an en-suite of one twin room, and a door handle was found to be broken in a resident's bedroom.
- Only one handrail was found in a number of en-suite facilities.
- There were some areas where wall and ceiling surfaces required sealing and redecoration to address gaps in these surfaces.
- An external porta cabin used, as a storage area for cleaning equipment and laundry trolleys, had signs of mould and damp on the ceilings.

Judgment: Not compliant

Regulation 28: Fire precautions

The day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example;

- An immediate action was issued to the provider in regards to inappropriate storage of fuel cans and detergent stored next to a generator. The person in charge had arranged for these items to be removed.
- A large electronic printing machine was noted to be in use along a means of escape. The use of electrical equipment and flammable materials could potentially create a fire risk.
- A number of oxygen cylinders were not securely stored in an external oxygen cage. This created a risk of cylinders falling over. Furthermore, the area around the cage was not kept clear from flammable items.
- An external gas shut-off lever was missing signage to indicate the purpose and how to operate it in the event of a fire.

- In an enclosed garden, a residents' smoking area was missing a fire blanket, and some residents were observed smoking without the use of a smoking apron.
- An external storage building separate to the designated centre was observed to be cluttered and untidy.
- The first floor staircase was found with cardboard boxes and items stored on the staircase. The storage arrangements and the quantity of flammable and combustible items created a fire load and obstructed escape routes for staff.

The means of escape for residents and emergency lighting in the event of an emergency in the centre was not adequate. For example;

- A fire exit from a dayroom and dining room was observed to be fitted with a curtain that obscured the fire exit. A key was required to open one of the double fire exit doors. However, the key was missing from the break glass unit at the door. Furthermore, the curtain was masking the location of the green break glass unit at the fire exit. These risks obscured fire equipment and could cause confusion in the event of a fire.
- There was a lack of emergency lighting to the front, rear and side external evacuation routes of the centre to provide the required illumination to evacuate residents to the designated assembly points, during a night time evacuation. Emergency lighting was missing at the external fire assembly point and at some external fire exits.
- Internally, emergency directional signage was confusing. For example, at the top of a corridor two running man signs pointed in opposite directions. Furthermore, one of the signs was a paper-type signage. An emergency directional signage was missing from a bedroom with an external fire exit. Emergency lighting was missing from a boiler and a meter room.

Arrangements for the maintenance of the means of escape, building fabric and building services were not fully implemented. For example;

- Several areas of the centre had service penetrations and holes through the fire-rated walls and ceilings that required appropriate fire sealing measures. These were noted in a boiler room, store rooms, linen rooms and a meter room.
- The ability of a sample of fire doors to prevent the spread of smoke and fire was compromised. A number of fire doors had gaps at the bottom and between doors, some of which were bedroom and compartment fire doors.
- A number of fire doors were missing door closers and smoke seals, and were fitted with non-fire-rated ironmongery and domestic-style door handles with a key locking mechanism. Some smoke seals had been painted over, which rendered them ineffective to contain smoke. Some cross-corridor doors failed to close fully or overlapped. The deficiencies identified to the building fabric and fire doors posed risks to residents' safety in the event of a fire.

Arrangements required improvement to ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre

and in so far as is reasonably practicable, residents, were aware of the procedure to be followed in the case of a fire. For example;

- Fire drill records available demonstrated that staff were practising compartment fire drills on a monthly basis. The largest compartment can accommodate up to eight residents with a mixture of high, medium and low dependencies. Three staff members were rostered during night-time hours. The evacuation procedures outlined that two staff members were required to assist residents during an evacuation, while the third staff member stays at the fire panel. As a result, there were not enough staff available to supervise the remaining residents in their sleeping areas or to meet the fire brigade at the front door upon arrival. This was not aided by the main fire panel being located in the middle of the building, instead of being located at the front entrance. These arrangements could pose a risk to the residents.
- These risks were also previously noted in fire drill records reviewed on the day that stated; increased vigilance and a review of staffing supervision to areas beyond the evacuated compartment was recommended as there was a risk of residents from adjacent compartments inadvertently entering the affected area. In addition, a fire door failed to close when the fire alarm activated to a bedroom during a fire drill.
- As a result, fire drill records and evacuation procedures did not provide assurances that there were; adequate supervision of the remaining residents in the centre during an evacuation or to meet the fire brigade on arrival. This created a risk to residents.

The registered provider did not make adequate arrangements for containing fires and the arrangements in place for the detection of a fire required improvement. For example;

- Inspectors observed that the fire doors to a number of bedrooms were not fully compliant. Bedroom doors appeared to be light, were fitted with non-fire-rated ironmongery, domestic-style door handles and locking mechanisms and some were missing door closers and fire seals. These deficiencies were found on doors to an oxygen clinical room and store rooms. In addition, fire tags were not present, nor were test certificates available to confirm the fire rating of these doors.
- Fire detection was missing from a store room. This created a risk of a fire not being detected in this area.
- A number of ceiling access hatches appeared to not provide the required fire resistance to the fire-rated ceilings.
- A number of ceiling recessed lights were observed in some rooms. This created a risk of breaking the fire-resistant barrier of a ceiling, allowing flames and smoke to enter the void above.
- A plaster boarded ceiling in a meter room was observed to have exposed joints between boards and was not taped or jointed. Numerous penetrations were found through the ceiling. This impacted on the fire containment measures in this room.
- A store room along a means of escape corridor was being used to store activity equipment and items. Inspectors noted the room was not fitted with

a fire door. A large hole was found through the wall of this room due to the door closing mechanism needing to be accommodated. Furthermore, a single layer of plasterboard was used to form the walls of the store room, and this could not ensure that the wall linings would provide the required fire rating enclosure for a store room.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the residents' assessments and care plans found that care plans had not been reviewed as required under Regulation 5. For example, a number of care plans were not reviewed formally at intervals not exceeding four months.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate medical, health care and social care professionals and services to meet their assessed needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The provider promoted a restraint-free environment in the centre, in line with local and national policy. The provider had regularly reviewed the use of restrictive practises to ensure appropriate usage.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights to exercise choice and for their privacy and dignity were not consistently upheld. For example;

- Due to environmental limitations and insufficient space around the bed, all residents in the 10 twin-occupancy bedrooms could not exercise their choices

regarding movement and access to facilities without interfering with the rights of other residents in their rooms.
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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Bailey's Nursing Home OSV-0000316

Inspection ID: MON-0047233

Date of inspection: 10/03/2026

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 files have been reviewed by HR and PIC to ensure they are now complete and contain all information required by the regulations, including staff member's identification, full employment history, and references from recent employers. All staff files in Baileys are fully up to date. All new staff will have files completed with relevant information and all staff files will be audited 6 monthly by PIC and HR.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1.Fire and safety (regulation 28) To provide a more robust oversight of fire safety in the centre it is proposed to appoint a competent member of staff, reporting directly to the Person in Charge, to oversee all aspects in relation to fire safety as Fire Safety Manager. Support will be given to that appointee with necessary training and mentoring as required and provide back-up staff member as cover and to aid with onerous checks. It is proposed to carry out laundry duties at night thus resulting in an extra member of staff on the premises who will also be trained as necessary in all aspects of evacuation and supervision of residents. This will aim to prevent unintentional ingress of residents from other areas during a compartment evacuation and provide increased vigilance and a review of staffing supervision to areas beyond the evacuated compartment as was	

recommended .

2.Oversight of nursing documentation:

The Person in Charge (PIC) will implement enhanced auditing and supervision systems to ensure all nursing documentation and care plans are completed accurately, reviewed regularly, and reflect residents' current assessed needs.
The Person in Charge (PIC) and Clinical Nurse Manager (CNM) will conduct care plan audits weekly to ensure all care plans are reviewed, this will allow management to increase oversight by covering all careplans quarterly. Audit findings will be discussed at clinical governance meetings to ensure ongoing compliance.
Nursing allocations will also be reviewed and revised regularly to ensure appropriate distribution of responsibilities and effective oversight of residents' care planning and documentation.
Random checks will be implemented by the Person in Charge (PIC) and ADON/ Clinical Nurse Manager (CNM) to monitor the progress and quality of care plan updates, ensuring that documentation is completed accurately and in a timely manner, taking into account when known changes have happened for that resident
that should be reflected in their assessment and care plan
Staff nurses will receive refresher training on person-centred care planning on hse land.
Management team are currently preparing in house training on our assessment and care planning system, to
support staff and ensure everyone has good knowledge and competence to complete care plans.

3.Oversight of records management:

Following the inspection, it was identified that two staff files were unavailable on the day of inspection and some required documentation was incomplete. This issue has now been fully addressed, and all staff files have been reviewed by HR and PIC to ensure they are complete, accurate, and up to date.
To prevent recurrence, the PIC has implemented a robust staff file oversight and compliance monitoring system. This includes a centralised staff file checklist, 6 monthly audits of all staff records, tracking of mandatory documentation and expiry dates, and designated responsibility for file maintenance and review with the support of HR. A secure filing and retrieval process has also been introduced to ensure all files are readily accessible during inspections. Any missing or expiring documentation will be escalated immediately to management and followed up within agreed timeframes.

4.Residents' rights (Regulation 9)

The provider acknowledges that oversight arrangements required strengthening to ensure residents' rights were consistently
promoted and upheld and that a person-centered environment was maintained for all residents. In response, the Person in
Charge (PIC) has implemented enhanced governance and oversight systems within the centre. This includes increased management presence on the floor, regular resident

consultations and feedback meetings, and ongoing staff guidance and supervision to ensure residents' choices, privacy, dignity, independence, and preferences are always respected. A residents survey is underway, focusing on the residents preferences to guide management on what they would like to see for the room layouts, this will be considered in the planning of the new build as well as guide any current changes that can be made to make them more comfortable and uphold their rights, while extension works are in progress, attached are options for room layouts to meet specified guidelines, although an interim measure it will meet the guidelines to uphold residents right by having adequate space and their bed,chair,locker and clothes storage within that area .Staff have been reminded of their responsibilities in relation to residents' rights and person-centred care, and this will continue to be monitored through daily oversight, audits, and staff meetings. Residents are being kept fully informed at residents meetings of planned works and their input is being considered and guiding all plans.

5.Premises:

Planning permission has been granted to build new extension which will consist of 8 single occupancy bedrooms, all with ensuites. This will allow us to reduce our 10 shared rooms to singles as well as including additional storage for equipment. The provider has planning permission approved and is intended to issue a Commencement Notice in a matter of weeks to the local authority, at that stage we will have a Programme of Works in place and the project will proceed and it is not anticipated that there will be any delays on site. For the most part the project is a simple construction except for the linking in to the existing. We will provide a provisional completion date on submission of the Commencement Notice.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
We are committed to continuous improvement and ensuring that our premises meet the highest standards of safety, comfort, and regulatory compliance. We will continue to monitor, assess, and adapt our environment in line with residents' needs and preferences, and in accordance with Regulation 17. Planning permission granted on a proposed new build which will consist of 8 single occupancy bedrooms, all en suites. This will allow us to reduce our 10 shared rooms to singles as well as including additional storage for clothing. Attached are options for room layouts to meet specified guidelines, although an interim measure it will meet the guidelines to uphold residents right by having adequate space and their bed,chair,locker and clothes storage within that area.

Staff have been reminded of their responsibilities in relation to residents' rights and person-centered care, and this will continue to be monitored through daily oversight, audits, and staff meetings. Residents are being kept fully informed at residents' meetings of planned works and their input is being considered and guiding all plans.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: To provide a more robust oversight of fire safety in the centre it is proposed to appoint a competent member of staff, reporting directly to the Person in Charge, to oversee all aspects in relation to fire safety as Fire Safety Manager. Support will be given to that appointee with necessary training and mentoring as required and provide back-up staff member as cover and to aid with onerous checks.

Immediate action undertaken is noted regarding the inappropriate storage of fuel cans. Above Fire Safety Manager appointee to ensure this does not re-occur.

A solution to the location of the printing machine has been identified so that with some re-arranging of the office and reconfiguring of its door the printer will be relocated into the office.

Oxygen cylinders are stored correctly now and items removed from vicinity of cage. Staff dealing with oxygen tanks to receive training with regard to oxygen storage and be educated regarding risks involved. Area around oxygen cage to be regularly inspected by Fire Safety Manager appointee as well as the storage of the cylinders.

Provide signage and operational instructions for the external gas shut-off lever.

With regard to the enclosed garden residents' smoking area it is proposed to provide a fire blanket. Ensure smoking aprons are used. Staff to receive refresher training and this area to come under the remit of the Fire Safety Manager appointee. Note that some people are not incapacitated, are more independent and capable of being in full control while smoking.

Remove unnecessary items from the external storage building separate to the designated centre. Provide shelving at floor level to ensure no stock is stored on floor. Keep all items on shelves and clear incoming goods off floor in a timely manner. Keep passages between racks clear at all times. Provide refresher staff training.

Stairway and landing together with the route from the bottom of the stairs to the

external door to be kept clear AT ALL TIMES in the external storage building separate to the designated centre. This area will come under the remit of the Fire Safety Manager appointee.

With regard to the fire exit from a dayroom and dining room it is noted that doors should open in the direction of escape without the use of a key from the escape side. Fit compact blind to each door leaf for privacy and sun blocking if desired, to avoid any barrier to exit. This door is fitted with a maglock, and it will be readily openable without restriction as the activation of the fire alarm will release the maglock automatically and in the event of a fault it reverts to unlocked. This is checked at every weekly fire drill.

It is proposed to carry out evaluation of external emergency lighting and signage on all routes to the assembly point, fit lighting and signage as necessary.

Correct the emergency directional signage to avoid confusion. Replace the paper-type signage with regulation signage. Fit an emergency directional sign which was missing from a bedroom with an external fire exit. Fit emergency lighting to the boiler and meter room.

It is proposed to provide fire sealing to all service penetrations and holes through fire-rated walls and ceilings and carry out an audit of the building to ensure that all such penetrations are identified and dealt with.

A full door survey has been completed and results are being collated but it is safe to say that numerous defects have been identified. Contractor has been appointed and an on-site action plan is being formulated to address issues in relation to fire doors which will have to take into account the residents' needs and the fact that it is a live site.

It is proposed to carry out laundry duties at night thus resulting in an extra member of staff on the premises who will also be trained as necessary in all aspects of evacuation and supervision of residents. This will aim to prevent unintentional ingress of residents from other areas during a compartment evacuation and provide increased vigilance and a review of staffing supervision to areas beyond the evacuated compartment as was recommended.
Local Fire Brigade Station officer was on site carrying out their regular checks externally about a month ago and is due to visit in a number of weeks during which the issues of meeting the fire brigade in the event of an incident will be discussed and agreed.
Consider providing walkie-talkies to staff on night duty to speed up communication.
Expand staff training to cover the issues raised

It is accepted that Certs are unavailable for some doors which were installed some 30 odd years ago and a plan of action will be put in place to replace those doors. (The supplier does remember supplying the doors but with the passage of time records are no longer available)

Fit detector immediately to the store room and commission and certify it.

Replace ceiling access hatches with proprietary fire resistant hatches which will be certified.

Check for the presence of intumescent "hoods" over the recessed lighting. Alternatively (and preferably) replace recessed lighting with surface mounted lighting following replacement of the affected areas of the ceiling.

There is a concrete slab above the plasterboard ceiling in the meeting room. And service penetrations to be checked and fire stopping to be provided where necessary.

If no Cert is available replace the door for a certified fire door to the store room along the "means of escape corridor". Check the configuration of the door closer to ensure it does not cause further damage. Check make-up of stud walls and replace or add additional layers of fireline plasterboard as necessary in accordance with manufacturers' instructions to achieve the required fire resistance.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The Person in Charge (PIC) and Clinical Nurse Manager (CNM) will conduct care plan audits weekly to ensure all care plans are reviewed and audited quarterly. Nursing allocations will also be reviewed and revised on an ongoing basis to ensure appropriate distribution of responsibilities and effective oversight of residents' care planning and documentation. Random checks will be implemented by the Person in Charge (PIC) and ADON/ Clinical Nurse Manager (CNM) to monitor the progress and quality of care plan updates, ensuring that documentation is completed accurately and in a timely manner.

A system will be implemented to ensure all care plans are formally reviewed at least every four months, with clear assignment of responsibility to named staff members for scheduling and completion of reviews. A central tracking and auditing system will be introduced to monitor review dates and flag upcoming or overdue reviews to prevent recurrence of non-compliance. Staff will be re-trained on the requirements of Regulation 5, with emphasis on timely review, documentation standards, and person-centred updating of care plans in line with changing needs. In addition, monthly audits conducted by the clinical manager or person in charge to ensure compliance is maintained and any gaps are addressed promptly. This structured approach will ensure all care plans remain up to date, support safe and effective care delivery, and achieve sustained regulatory compliance.

Regulation 9: Residents' rights	Not Compliant

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

A compliance action plan has been developed consistently uphold residents' rights to choice, privacy, and dignity due to space limitations in 10 twin-occupancy bedrooms.

Immediate actions include completing a risk assessment of all shared rooms, reinforcing staff guidance on privacy, consent, and dignity, improving care coordination, and introducing measures such as privacy screens and staggered care routines to reduce disruption between residents. A residents survey is underway, focusing on the residents preferences to guide management on what they would like to see for the room layouts, this will be considered in the planning of the new build as well as guide any current changes that can be made to make them more comfortable and uphold their rights. . Attached are options for room layouts to meet specified guidelines, although an interim measure it will meet the guidelines to uphold residents right by having adequate space and their bed,chair,locker and clothes storage within that area.

Care plans will be updated to reflect individual privacy needs and support more person-centred routines, while environmental adjustments will be made where possible to improve access and movement within rooms.
In the medium to long term, the service will reduce reliance on twin-occupancy accommodation in line with best practice standards. Importantly, a new extension is planned comprising 8 single-occupancy en-suite bedrooms, which will significantly improve privacy, dignity, and autonomy for residents and address many of the current environmental constraints.

Progress will be monitored through ongoing audits, resident feedback, and governance oversight to ensure sustained compliance and improvement.

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(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	31/08/2027
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.	Substantially Compliant	Yellow	30/04/2026
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	Not Compliant	Orange	31/08/2026

	effectively monitored.			
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	31/07/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/10/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/08/2026

Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/07/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/08/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	31/08/2026