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:	Elm Hall Nursing Home
Name of provider:	Springwood Nursing Homes Limited
Address of centre:	Elm Hall Nursing Home, Loughlinstown Road, Celbridge, Kildare
Type of inspection:	Unannounced
Date of inspection:	10 April 2026
Centre ID:	OSV-0000034
Fieldwork ID:	MON-0050179

About the designated centre

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

Elm Hall Nursing Home is a purpose built nursing home close to the village of Celbridge and is approximately 15 minutes from west Dublin. The centre can accommodate 62 residents, both male and female and primarily over the age of 55. The centre provides a wide range of 24-hour nursing care services to residents, including long term nursing care, palliative care and convalescent and respite care. There are 58 single and two twin bedrooms in the centre, all of which have en-suite facilities. Communal space is also available to residents and includes day rooms, dining rooms and quiet rooms. The centre is designed and operated to ensure every comfort is afforded to residents. The centre endeavours to a provide a high quality of nursing care to all residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61

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
Friday 10 April 2026	07:25hrs to 15:45hrs	Maureen Kennedy	Lead

What residents told us and what inspectors observed

On the day of inspection, the inspector spoke with many residents to gain insight into their experience of living in Elm Hall Nursing Home. Residents spoken with were complimentary in their feedback and expressed satisfaction about the standard of care provided. Residents reported that the care was 'very good' and that staff had the 'patience of a saint'. Residents' families and friends were observed to visit residents on the day of the inspection. Visitors confirmed they were welcome to the home at any time and praised the care. There were 61 residents living in the centre on the day of this unannounced inspection.

The inspector arrived early at the centre and used the opportunity to speak with both night-time and day-time staff in various units. The inspector found a calm, quiet atmosphere as residents were observed sleeping in their rooms while some residents were already up. The inspector observed that there were sufficient staff around to meet residents' needs. There were no agency staff used in the centre and all staff who spoke with the inspector knew the residents and were familiar with their needs. Staff were kind and caring in their interactions with residents and were respectful of residents' communication and personal needs. Staff were observed busily attending to residents' requests for assistance in a timely manner.

Overall, the premises was designed and laid out to meet the needs of the residents. The general environment and residents' bedrooms, communal areas and toilets inspected appeared clean and clutter-free. The inspector observed good practices in relation to standard precautions to reduce the spread of infection. Staff were observed to have good hand hygiene practices. The inspector observed the dedicated housekeeping room for the storage and preparation of cleaning products and housekeeping trolleys. Household staff spoken with explained all procedures and the inspector observed the cleaning schedules and records which were well-maintained.

The inspector observed that the provider was proactive in maintaining and improving the facilities and physical infrastructure in the home, through ongoing maintenance and renovations. For example, the inspector was told that new sewage works were recently completed to address drainage and pipe issues within the home. The inspector was aware of the planned refurbishments for the home. The provider had ensured the residents and relatives were consulted and were informed of the planned works through regular meetings.

As highlighted in the previous inspection of June 2025 and in line with the providers' compliance plan, fire door replacement and remedial works had been completed. Regarding the laundry facility, which is a high risk area and is not effectively compartmented, the inspector was informed that the plans to relocate this service are on schedule. While awaiting the ongoing works to improve fire safety at the centre, the registered provider was taking adequate precautions to ensure that

residents were protected from the risk of fire. Fire safety arrangements in the home were evident with good signage displayed on each area. The external fire exit doors were clearly sign-posted and were free from obstruction and all staff had received training in fire prevention and emergency procedures including evacuation procedures with records of evacuation drills available for review.

The inspector noted that following the last inspection, the registered provider had put in place an improvement plan to enhance residents' individual assessment and care planning. However, this inspection identified ongoing gaps with assessment and care plan records as discussed later in the report.

Residents were supported to enjoy a good quality life in the centre. Residents had access to television, radio and newspapers. A range of activities were available to residents, with the activities schedule displayed on a notice board in the corridors and communal areas. The inspector observed residents participating in individual activities and chair exercises on the morning of the inspection and actively participating in the Mass in the afternoon, through singing hymns.

There was a calm unhurried atmosphere in the centre's dining rooms as residents dined. There was a menu available with choice of courses and a variety of drinks were offered to residents. The meals provided appeared appetising and were served hot. The inspector observed adequate numbers of staff available offering encouragement and assistance to residents as required, and staff spoken with were knowledgeable of residents' dietary needs, including relevant modified diets.

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 impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspector found that in general, residents benefited from a well-run centre with good leadership and good governance and management arrangements in place. However, there were also repeated findings in respect of care planning arrangements which meant that the provider's management systems required to be strengthened. Furthermore, the registered provider failed to ensure a directory of residents was maintained in line with regulatory requirements.

This inspection was carried out to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). The registered provider of Elm Hall Nursing Home is Springwood Nursing Homes Limited, which is part of the CareChoice group.

There was a clearly defined management structure in place with a schedule of regular team meetings including clinical governance, management and staff

meetings. Minutes of these meetings were provided to the inspector. There was an annual review of the centre and a quality improvement plan in place. The residents' opinions and their views were taken into account when developing this annual review. The management team had developed audits that identified where improvements were required. They used these audits to implement improvement plans and drive quality care. Records of these audits were available for the inspector to review.

The inspector was informed that following the last inspection, the registered provider, in line with the compliance plan, had ensured that staff were provided with additional assessment and care planning training. While care planning audits had been carried out, they had failed to identify that there continued to be gaps in the nursing documentation, as observed during the inspection, and as further detailed under Regulation 5: Individual assessment and care planning.

The inspector was informed that the centre was moving towards being 'paper-free' with all records available electronically. Documents requested by the inspector including, written policies and procedures, records of meetings and audits and the residents' guide were available for review and were compliant with the legislative requirements. However, a directory of residents was not available when requested as discussed under Regulation 19.

Regulation 19: Directory of residents

While the provider assured the inspector that all the information required under Schedule 3 of the regulations was available within the centre, a directory of residents in paper or electronic format was not available when repeatedly requested on the day of inspection.

Judgment: Not compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that protected residents against injury and against other risks, including loss or damage to their property.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the systems in place for the oversight and monitoring of care and services provided for residents, further action was required by the registered provider to achieve regulatory compliance as follows:

- While regular auditing on various aspects of the service was completed, the audit process was not sufficiently robust to identify areas for improvement. For example, care planning audits conducted had not picked up on the gaps in documentation observed on this inspection as identified under Regulation 5: Individual assessment and care plan. This is a repeat finding.
- The registered provider did not ensure a directory of residents was maintained.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A copy of the complaints procedure was available within the centre with a summary outlined in the residents' guide. There was a nominated person for managing complaints and a review officer had been appointed. Advocacy services posters were on display throughout the centre. Complaints audits took place and found complaints were being investigated and responded to within the required time frames. There was no open complaint in the centre at the time of inspection.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures as required in Schedule 5 of the regulations were available for review, and had all been updated within the last three years.

Judgment: Compliant

Quality and safety

Overall, the inspector was assured that residents were supported and encouraged to have a good quality of life in the designated centre and that their healthcare needs were met. Residents and visitors voiced their satisfaction with the care provided in

the home. However, improvements continued to be required in relation to individual assessment and care planning, which will be discussed under Regulation 5.

Residents' health and well-being were promoted in the centre, and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as tissue viability nurse, physiotherapy, dietitian, and speech and language, as required.

The inspector found that all reasonable measures were taken to protect residents from abuse. A notice board had all relevant information available to support residents, including details on the Ombudsman and advocacy services. There was a policy in place which covered all types of abuse and the inspector saw that all staff had received mandatory training in relation to detection, prevention and responses to abuse. Staff had An Garda Síochána (police) vetting prior to starting work in the centre.

The inspector viewed bedrooms with permission and found that they were warm, bright and homely spaces. Most were personalised with ornaments and photographs, while some had lovely plants and furniture from home. Bedrooms were observed to have sufficient storage space for residents' clothing and personal possessions. Many residents told inspector that they were satisfied with their accommodation and one resident talked about the 'great woman' in the laundry who 'looks after everything' for her.

Regulation 12: Personal possessions

The inspector saw that residents' rooms had adequate storage for clothing and that residents retained control over their own clothes. There was an effective laundering and labelling system in place that ensured that all clothes were returned to residents in a timely manner.

Judgment: Compliant

Regulation 20: Information for residents

The residents' guide for the designated centre was available. This guide contained all of the required information in line with regulatory requirements.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' care plans found that they were not fully in line with the requirements of the regulations. For example:

- An assessment of care on a recent admission was not completed within 48 hours of admission.

Care plans which prescribed the required interventions to support residents' care were not consistently implemented in practice. For example:

- Requirements of two and four hourly repositioning were outlined in the care plan as informed by a risk assessment, but records showed that resident repositioning was not within the prescribed time frames. This posed a risk that residents assessed as being at risk were not effectively protected from the risk of pressure sore or skin breakdown.

Judgment: Substantially compliant

Regulation 6: Health care

Records showed that residents had access to medical treatment and expertise in line with their assessed needs, which included access to a range of healthcare specialists.

Judgment: Compliant

Regulation 8: Protection

The provider had an up-to-date Safeguarding Policy, and measures in place to protect residents from abuse. Appropriate pension-agent arrangements were in place to safeguard resident's finances.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 19: Directory of residents	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 20: Information for residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Elm Hall Nursing Home OSV-0000034

Inspection ID: MON-0050179

Date of inspection: 10/04/2026

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 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:

The registered provider has reviewed the findings of the inspection and has implemented measures to ensure that the Directory of Residents can be promptly made available to inspectors upon request, in line with the requirements of Regulation 19. The Directory of Residents is maintained in an electronic format in compliance with Schedule 3 of the regulations and contains all required information and a printed copy can be generated and made available on request.

A standard operating procedure (SOP) has been developed and issued to provide clear instruction to relevant staff on how to access and generate the Resident Register from the electronic system. This guidance has been communicated to staff and will support prompt retrieval of the report when requested during future inspections or internal governance reviews

In addition, weekly management audits of the Directory of Residents will be undertaken to ensure that all information required under Schedule 3 of the regulations is accurate, complete, up to date, and readily accessible at all times.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider has reviewed the governance and management systems within the centre following the findings of the inspection to ensure that services provided are safe, appropriate, consistently monitored, and effectively governed.

The existing clinical audit programme has been strengthened to enhance oversight of care planning documentation, resident assessments, and overall regulatory compliance. Care plans will continue to be audited monthly, with additional focused reviews undertaken by the Person in Charge and Clinical Management Team to ensure compliance with regulatory requirements and to identify areas requiring improvement.

The gaps identified within the inspection report have been shared with all auditors, and additional training in auditing practices is being implemented to ensure the audit process is sufficiently robust, effective, and capable of identifying areas requiring improvement.

Weekly spot checks on care records will be conducted by the management team to identify any gaps in admission documentation, overdue assessments, any gaps in care plans and other relevant documentation, and any areas where prescribed care interventions have not been appropriately recorded or completed.

All actions identified through audits and governance oversight systems will be discussed at clinical governance and management meetings. Action plans will be developed, monitored, and reviewed to ensure that improvements are implemented effectively and sustained in practice.

All staff nurses will complete refresher training in care planning and clinical documentation over the next two months to support improved documentation practices and consistency in person-centred care planning.

Actions pertaining to Resident directory are outlined separately under Reg 19.

The Person in Charge and Clinical Nurse Managers will continue to undertake regular supervision, spot checks and monitoring of documentation practices to support ongoing compliance and continuous quality improvement within the centre.

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 registered provider has reviewed the findings relating to assessment and care planning practices within the centre and has implemented additional measures to strengthen oversight and ensure compliance with regulatory requirements.

All residents' assessments and care plans are being reviewed to ensure assessments are completed within the required regulatory time frames following admission and that care plans accurately reflect residents' assessed needs and prescribed interventions.

All nursing staff have been reminded of the requirement to complete resident assessments and care plans within 48 hours of admission and to ensure care plans accurately reflect residents' assessed needs and prescribed interventions.

All staff nurses will complete refresher training in care planning and clinical documentation over the next two months to support consistent practice and improve the quality and accuracy of documentation within the centre.

Care plans will continue to be audited as part of the scheduled monthly clinical audit programme to ensure:
• assessments are completed within required timeframes,
• care plans are person-centred and reflect residents' current needs,
• prescribed interventions are clearly documented,
• and care delivered is consistent with the care plan.

Audit findings and identified actions will be reviewed through clinical governance meetings to ensure ongoing oversight, sustained improvement, and continued compliance with regulatory requirements.

Weekly documentation reports will also be reviewed by the management team to identify overdue assessments, incomplete care plans, gaps in documentation and areas requiring follow-up action.

The Person in Charge and Clinical Management Team have implemented enhanced monitoring systems to ensure prescribed interventions, including repositioning schedules, are consistently implemented and accurately documented in practice. Daily and weekly spot checks of repositioning records and care documentation will be undertaken to identify any gaps in compliance and ensure residents at risk of pressure damage are appropriately protected.

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 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Not Compliant	Orange	01/05/2026
Regulation 19(2)	The directory established under paragraph (1) shall be available, when requested, to the Chief Inspector.	Not Compliant	Orange	01/05/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/05/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident	Substantially Compliant	Yellow	31/05/2026

	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	31/05/2026