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:	Friars Lodge Nursing Home
Name of provider:	G & T Gallen Limited
Address of centre:	Convent Road, Ballinrobe, Mayo
Type of inspection:	Unannounced
Date of inspection:	20 March 2026
Centre ID:	OSV-0000342
Fieldwork ID:	MON-0048731

About the designated centre

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

Friars Lodge Nursing Home is a designated centre for Older People. The building is purpose-built. 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 Ballinrobe town. Residents have access to an enclosed garden area. The centre provides accommodation for a maximum of 64 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:	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 20 March 2026	09:30hrs to 16:00hrs	Michael Dunne	Lead

What residents told us and what inspectors observed

Overall, the findings from this inspection confirmed that residents were satisfied with the care and support provided. Feedback from residents was positive regarding their quality of life. Residents told the inspector that they felt safe in the centre, were well cared for, and that they enjoyed the food provided. The inspector spoke with several residents over the course of the inspection, both in their bedrooms, and in communal areas of the centre. The feedback received from residents was positive regarding their lived experience. One resident said " staff are good, I'm happy here, and well-looked after", while another said " that they wished their respite stay was longer". The inspector also spoke with visitors, and they also expressed satisfaction with the quality of care provided in the centre.

This unannounced inspection was conducted with a focus on adult safeguarding, and to review the measures the provider had in place to safeguard residents from all forms of abuse. Upon arrival, the inspector was met by the person in charge and a director of the company. Following a brief introduction, the inspector commenced a walk around of the designated centre where they had the opportunity to observe the care environment, and speak with residents, and staff as they began their daily routines. Following the walk around, the inspector met with the person in charge, and both directors of the company to discuss in more detail the format of the inspection, and to discuss the findings from the walkabout.

There was a relaxed atmosphere in the centre with staff observed assisting residents in a respectful and unhurried manner with their mobility and their personal care requirements. Observations confirmed that staff were aware of residents' assessed needs, and were able to provide care and support in line with residents' preferences. Staff were observed ensuring that residents has sufficient liquid for their hydration needs. Observations found that these interactions were valued by the residents, and they enjoyed the banter, and chat with the staff members.

A number of residents said that they liked to have their breakfast in their rooms, and that this was their choice. Other residents were up and about and following their normal routines. Residents who required support with their personal care were provided with appropriate support in a dignified and respectful manner. All residents observed during the inspection were wearing suitable clothing and footwear. All equipment used to support residents with their transfer, or with their mobility was found to be clean, and in good working order. The inspector noted that there was an organised response when call-bells were activated, and all call-bells were responded to within an acceptable time frame.

Residents had free movement throughout the centre, and appropriate measures were in place to restrict resident access to store rooms, sluice rooms, and the kitchen facilities. There were several communal areas available for residents to use both internally and externally. Resident communal rooms were spacious,

comfortable, warm, and contained sufficient seating for residents to use. There were no restrictions for residents accessing two enclosed garden areas, which contained flowers, shrubs, and several garden ornaments. Access to these areas was step-free, with well-maintained paths to support access for residents using mobility equipment. However, observations confirmed that these areas were not well-maintained, and some areas of the garden were being used to store used kitchen equipment that was due for collection. There was an area set aside in the garden for residents who wished to smoke.

There was a well-established activity programme based on residents' interests and capacities. A weekly activity schedule was advertised in the centre to inform residents of what was provided. Residents told the inspector that there is always something to do, and that they enjoyed attending activities with the other residents. There were numerous activities provided on the day of the inspection which included a well-attended a weekly bingo session, card games and music sessions. A residents' meeting was organised on the day of the inspection. Mass was celebrated on the day, and was well-attended by the residents. Following, the mass the priest was observed visiting residents who had remained in their bedrooms.

Residents' dietary requirements were well-catered for. There was a choice of menu available for residents, which included a lamb stew or a pan-fried haddock meal. There were various options for residents who did not like what was on the menu. Residents said that the quality of food is always good, and that they enjoy the dining experience. Residents who required support with their eating, and drinking were provided with timely assistance to enjoy their meal. The inspector attended a meal service, and found it to be well-organised, and appropriate for the assessed needs of the 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 the quality and safety of the service being delivered.

Capacity and capability

The findings of this inspection were that the provider had, for the most part, put in place effective systems and processes to ensure residents were safeguarded and protected from abuse. However, this inspection also found that there were significant delays in the recruitment of key roles to support the implementation of these processes, which had the potential to impact on the ability of the provider to ensure the effective oversight of the service.

One of the directors of the company, who previously worked as the person in charge of this centre, was assisting in the clinical oversight of the designated centre. They were supporting the person in charge on a part-time basis. This arrangement was

not sustainable on a long-term basis, and had the potential to impact on the required levels of clinical oversight for this centre.

G & T Gallen Limited is the registered provider for the designated centre, and consists of two directors who both work in the centre. The person in charge is supported by a director of the company on a part-time basis, and a team of staff nurses, health care assistants, housekeeping, catering, maintenance, activity, and administration staff.

The inspector found that the roster was not well-managed as records confirmed that staffing levels were not consistent with those set out under the designated centre's statement of purpose submitted as part of the registration of the centre in 2024. There were vacancies for two senior healthcare assistant roles; however, the provider informed the inspector post inspection that one of these roles had since been filled. A review of the rosters found that these roles were not covered by the provider. However, in instances where gaps appeared on the roster for other roles, they were usually filled by existing team members.

The inspector found inconsistencies regarding the monitoring and supervision of residents. Three residents located in one of the sitting rooms were observed to be unsupervised. The inspector was informed by one staff member that these residents were under 15- minute supervision, while another staff member said that they were supervised every 30 minutes. The inspector found that these residents did not have access to call-bells to access staff support, and the inconsistencies surrounding their monitoring had the potential to impact on their wellbeing. The inspector reviewed a sample of governance and management documentation, including audit records, meeting minutes, and complaint records. The inspector found that there were systems in place which provided oversight, to monitor the quality of care provided to the residents.

Overall, where improvements were identified, an action plan was developed to address the issues identified. There were effective channels of communication within the team, with meetings held at all levels to discuss the service. An annual review of the service was conducted by the provider for 2025. There was effective collaboration with residents to access their views on the service, which were incorporated into the review document dated February 2026. There was a detailed quality improvement plan for 2026, which the provider was currently working through.

There was a clear safeguarding policy in place that set out the definitions of terms used, responsibilities for different staff roles, types of abuse, and the procedure for reporting abuse when it was disclosed by a resident, reported by someone, or observed. The management team were clear on the steps to be taken when an allegation was reported. The staff team had all completed relevant training, and were clear on what may be indicators of abuse, and what to do if they were informed of or suspected abuse had occurred. There was effective oversight of staff training requirements with a focus on providing staff with knowledge, and tools to carry out their roles effectively.

Regulation 15: Staffing

The registered provider did not ensure that the number and skill-mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre. This was evidenced by:

- The assistant director of nursing (ADON) role was covered on a part-time basis by a director of the company. This was a reduction of clinical hours available in the designated centre as the previous assistant director of nursing (ADON) role was a full-time role.
- Two senior health care positions were vacant and their roles were not covered on the roster, and this impacted on the availability of staff to provide supervision, and monitoring of resident daily care.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training as part of their professional development, and to support them in delivering effective care, and support to meet the assessed needs of the residents. Staff completed a selection of training as part of the systems to safeguard residents, and promote their rights in the centre. The training included safeguarding of residents from abuse, fire safety, manual handling, infection prevention and control, and restrictive practice. Training records indicated that regular training is provided for cardio-pulmonary resuscitation (CPR). Records confirmed that clinical staff attended medication management, and wound management to maintain, and promote their competence in these areas.

The provider developed a supplementary in-house training programme, which covered a number of themes associated with restrictive practices, such as consent, human rights, and the capacity of individuals to make informed decisions.

Judgment: Compliant

Regulation 23: Governance and management

The number of staff available to deliver the service on the roster was not consistent with the number of staff identified on the Statement of Purpose (SOP) submitted for registration dated 02 February 2024. For example:

- Both of the senior care assistant roles were vacant at the time of the inspection, and their roles were not covered on the rosters.
- The arrangements currently in place to cover the assistant director of nursing role (ADON) were not sufficient. One of the directors of the provider company was currently providing clinical oversight support on a part-time basis. This is discussed under Regulation 15: Staffing.

There were inadequate systems in place to ensure that residents were appropriately supervised. For example:

- Three residents in one communal room were unsupervised, and did not have access to call-bells to summon staff support should they require it.

Judgment: Substantially compliant

Quality and safety

Residents were supported and encouraged to have a good quality of life, which was respectful of their choices. Residents' autonomy was respected, with residents encouraged to live their lives according to their own preferences. There was evidence that residents were in receipt of positive health and social care outcomes, and that their assessed needs were being met by the registered provider. Regular consultation between the provider and residents ensured that residents' voices were being heard in this centre.

There was a focus on social interaction led by the activity co-ordinators. Residents had daily opportunities to participate in group or individual activities. Resident meetings were held on a monthly basis, and provided residents with opportunities to have their say, and discuss any topic they felt relevant. Residents were encouraged and supported both formally and informally to give feedback about the quality of the service provided. There was access to televisions, telephones, and newspapers on a daily basis, while residents who required the assistance of advocacy services were assisted to access this service. Residents were supported to practice their religion.

The inspector found that there was a focus on ensuring that residents maintained their links with the community. Many residents who lived in the centre were from the local community, and were supported to attend the local church and access amenities in the local town. There were links formed with local schools to attend the centre, which the residents enjoyed very much.

Residents' privacy and dignity were respected in their lived environment, and by the staff caring for them. Residents reported that they felt safe living in the centre. The inspector observed several staff and resident interactions, and found them to be supportive of residents' communication needs. Staff were aware of these needs and adapted their communication style and tone to promote residents' communication. These interactions were unhurried and provided residents with space and time to make their views known.

The provider had arrangements in place to ensure that all staff recruited to work in the designated centre had the required experience and qualifications to be able to carryout their work effectively. This also included acquiring a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 to ensure that potential staff were suitable to work with Vulnerable adults.

The inspector reviewed a sample of residents' care records. Records showed that nursing staff used validated tools to carry out assessments of residents' needs prior to, and on admission to the centre. These assessments included the risk of falls, malnutrition, assessment of cognition, and dependency levels. The inspector found that these assessments and care plans were completed within 48hrs of residents being admitted to the centre. Care plans reviewed included sufficient up-to-date information in relation to residents' current needs. This meant that these care plans provided adequate guidance, and direction to meet the residents' assessed needs.

A supportive approach was used by staff when providing care to residents who experienced episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were observed to be attentive and alert to residents' individual needs for support. There were effective systems in place to monitor and review residents' responsive behaviours in order to identify triggers, and the most appropriate response of intervention to maintain residents' safety and autonomy.

Regulation 10: Communication difficulties

Residents with communication difficulties were supported to communicate freely by staff who were aware of their communication needs. A review of records found that the resident's communication needs were regularly assessed, and a person-centred care plan was developed to ensure that appropriate levels of support were in place.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed several residents' care records, and spoke with a number of residents on the day. Care records confirmed that the person in charge completed a pre-admission assessment for all potential residents to ensure that the centre would be able to meet the person's needs.

Following admission, all residents had a comprehensive assessment of their needs completed within 48hrs. The assessment included potential risks such as skin integrity, falls, personal safety, and the resident's personal care support needs. Nursing staff worked collaboratively with residents, and where appropriate with their representative, to develop care plans setting out how the agreed care interventions would meet the resident's assessed needs. Care plans identified residents' self-care abilities, and this empowered residents to have an active role in their care.

A selection of care records reviewed on inspection confirmed that care plans were reviewed regularly by the nursing team, and were updated accordingly should the resident's care and support needs change.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspector found that residents experiencing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were in receipt of appropriate support to ensure their, and other residents' safety. Care plans were well-written, identifying triggers that may contribute to responsive behaviours, while identifying clear interventions to manage these situations should they arise. There was evidence available in the care records which indicated that the provider sought additional medical support to maintain resident safety when needed.

Records showed that where restrictive practices were introduced, such as bed rails, they were only introduced following an appropriate risk assessment, and where alternatives had been trialled prior to their introduction. There was evidence that the provider sought consent from the resident prior to the introduction of restraints. In instances, where the resident was unable to give consent for their introduction then the resident's representative was consulted.

The provider had systems in place to monitor environmental restrictive practices to ensure that they were appropriate, and there was good evidence to show that the centre was monitoring restrictive practices on a regular basis.

Judgment: Compliant

Regulation 8: Protection

The provider had arrangements in place to safeguard residents, and protect them from the risk of abuse. These arrangements were supported by policies and procedures that guided staff practices, and outlined the organisations response to safeguarding concerns.

There was effective oversight of staff training and development, a review of training records confirmed that all staff had attended safeguarding training. Discussions with staff on the day confirmed, that they were aware of their responsibilities in protecting residents from all forms of abuse. Staff said "that they found safeguarding training informative, and assisted them in their role in protecting residents from the risk of abuse".

The provider maintained effective oversight of schedule 2 records, a review of these records confirmed that all relevant documentation was in place prior to staff commencing work in the centre. There were policies and procedures in place to support effective management and the safeguarding of resident finances. A review of finances held on behalf of residents found that they were well-maintained, and reconciled on a regular basis by the provider.

Judgment: Compliant

Regulation 9: Residents' rights

There were facilities for residents to participate in activities in accordance with their interests and capacities. Residents expressed their satisfaction with the variety of activities available in the designated centre. There was a well-organised activity schedule on display for residents to review and choose what activities they would like to participate in. Several activities were provided on the day, including bingo, nail painting, word games, and puzzles. There were good interactions between staff and residents during these activities, with appropriate support provided to ensure all residents engaged and enjoyed the social activity provided.

There was a focus on empowering residents to make informed choices about their care and their lives. Resident meetings were held on a monthly basis, and residents were encouraged to attend and discuss issues of importance to them. Records of these meetings were maintained by centre staff, and discussed with residents who did not attend so that they would be informed of information about the centre. Restrictive practices was a standard agenda item discussed in resident meetings. Arrangements for how residents could access advocacy and register a complaint were advertised throughout the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Friars Lodge Nursing Home OSV-0000342

Inspection ID: MON-0048731

Date of inspection: 20/03/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider will ensure full Whole-Time Equivalent (WTE) Assistant Director of Nursing (ADON) cover until the newly recruited ADON/CNM is in post. A named senior nurse is rostered full-time in the ADON role and will continue to provide daily clinical oversight and governance. This arrangement is already in place and will remain until the new ADON/CNM has commenced and completed induction. Recruitment for the ADON/CNM position is underway, with interviews scheduled by15th August2026. Senior Healthcare Assistant (HCA) cover will be maintained. Two senior HCA posts have been filled, and these staff are now rostered to provide senior oversight at all times. The senior HCA roster will be reviewed weekly to maintain the appropriate skill mix and supervision. This action has been fully implemented since 1 July 2026. The Person in Charge (PIC) and ADON will conduct weekly staffing reviews to monitor staffing levels and ensure compliance with Regulation 15. These reviews will be documented in the governance meeting minutes. Weekly reviews commenced on 1 July 2026 and will continue on an ongoing basis.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Full WTE ADON cover will be maintained until the newly recruited ADON/CNM is appointed. A nurse is rostered full-time in the ADON/CNM role and has the required competencies and experience to fulfil this position. This arrangement is currently in place and will continue until the new ADON/CNM starts.	

All residents in communal areas will have call-bells within reach at all times. Daily checks will be carried out by staff while completing their supervision logs to ensure compliance. This action was implemented on 2 July 2026.
All staff will receive refresher training on supervision and call-bell access. Attendance sheets will be maintained. Training will be delivered onsite by the PIC and ADON, with all sessions scheduled for completion by 20 July 2026.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/08/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/08/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that	Substantially Compliant	Yellow	31/07/2026

	identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			