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:	Glengara Park Nursing Home
Name of provider:	Glengara Park Nursing Home Ltd
Address of centre:	Lower Glenageary Road, Dun Laoghaire, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	21 April 2026
Centre ID:	OSV-0000044
Fieldwork ID:	MON-0049628

About the designated centre

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

Glengara Park Nursing Home can accommodate 66 residents, both male and female. Residents are over the age of 18 years with varying conditions, including dementia, cognitive impairment, physical, neurological and sensory impairments. Residents with end-of-life and mental health needs are also accommodated. 24-hour nursing care is provided. Glengara Park Nursing Home is a purpose-built nursing home composed of 62 single and two double bedrooms. Each room is fully decorated and furnished. Residents are encouraged to bring personal belongings and small items of furniture where appropriate. The majority of the rooms have en-suite facilities. There is one large sitting room and one large family room situated on the ground floor. Other sitting areas around the house include a coffee dock and an activities room. Outdoor facilities include two large patio areas, one of which is secure. A sensory garden is accessible at the front of the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	63

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 21 April 2026	09:30hrs to 17:40hrs	Bernadette McDonald	Lead
Tuesday 21 April 2026	09:30hrs to 17:40hrs	Mary Veale	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out by two inspectors over one day. Inspectors greeted and chatted with a number of residents and spoke in more detail to 13 residents to identify their experiences of living in Glengara Park Nursing Home. Overall, residents were very positive about how they spent their days in the centre, and were highly complimentary of the staff. Residents reported feeling safe in the centre and expressed satisfaction at how the centre was run. These residents appeared appropriately dressed and well groomed. There was a general sense of well-being in this homely centre. Inspectors spoke with three visitors who gave positive feedback on the care provided to their relative.

Inspectors completed a walk around initially, followed by an introductory meeting with the person in charge and the assistant director of nursing (ADON). Inspectors observed staff attending in a courteous and respectful manner while attending to residents' morning care. Most residents were observed having their breakfast in their bedrooms, and inspectors observed that some breakfasts were left untouched and had gone cold in some of the residents' bedrooms. This is discussed further under Regulation 18: Food and nutrition.

The centre is set out over three levels and is a custom-built facility located in Dun Laoghaire. It is registered to accommodate a maximum of 66 residents in 62 single and two twin-occupancy bedrooms, which were located on each level of the centre. Many residents had personalised their rooms with personal possessions and photographs. One twin occupancy bedroom and 58 single occupancy bedrooms had an en-suite with a toilet and hand-wash basin. Residents in the remaining bedrooms had access to shared communal toilets.

Residents had access to a range of communal areas on each level. There was a large, bright dining room located on the lower ground floor, with a smaller multi-purpose room adjacent to this, which was also used as a dining room. The dining room had floor-to-ceiling windows and doors that opened out onto a secure garden area, which residents could access. The dining room tables were decorated with fresh flower arrangements that the residents later informed inspectors they had arranged. There was a coffee dock located on the lower ground floor, which opened out onto a secure patio area. Coffee and tea making facilities were available in this area. Residents have access to an outdoor space at the rear of the centre. Residents could access the rear garden from this patio area. Some improvements were required in the patio area. However, inspectors observed that some parts of the premises were worn and damaged and required repair, and this is discussed under Regulation 17: Premises.

Inspectors observed the dining experience at lunch time. There were two sittings, the first at 12.30pm in the small dining room and a second sitting in the large dining room at 13:00pm. Lunchtime dining was observed to be a relaxed and sociable

experience, with residents enjoying each others company as they ate. Meals were prepared in the centre's on-site kitchen. The menu, with the choice of two starters, two main courses and two dessert options, was displayed in the dining room. Residents confirmed they were offered a choice of starter, main meal and dessert. The food served appeared nutritious and appetising. There were drinks available for residents at mealtimes, and further drinks accompanied by snacks throughout the inspection day. Residents expressed praise for the food. Notwithstanding these, areas of improvement were required and are detailed under Regulation 18: Food and nutrition.

The centre provided a laundry service for residents. Residents said that their clothes were regularly laundered, returned to their rooms and that they did not have any complaints about the laundry service.

The weekly activities programme was displayed in the day room. The inspectors observed activities staff and residents having good humoured banter throughout the day, and saw staff chatting with residents about their personal interests. Residents were seen reading newspapers, watching television, listening to music and engaging in conversation. Books, games and magazines were available to residents. Activities on the day, included a reminiscing session in the main day room and a balloon activity. Residents were observed to be engaging in these activities and enjoying them.

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

Capacity and capability

The purpose of the inspection was to assess ongoing compliance with the regulations and standards and to follow up on the compliance plan from the last inspection in March 2025. The inspectors also followed up on statutory notifications and two pieces of unsolicited information submitted to the office of the Chief Inspector of Social Services since March 2025. This information was used to support the development of lines of enquiry for this inspection. Overall, the findings of this inspection were that Glengara Park Nursing home was a centre where there was a focus on ongoing quality improvement to enhance the daily lives of residents. The inspectors found that residents were receiving a good service from a responsive team of staff delivering safe and appropriate person-centred care and support to residents. However, the oversight and management of some areas of the service, including premises, food and nutrition, responsive behaviour, assessment and care planning, infection control and fire precautions, were not fully in line with the requirements of the regulations.

Glengara Park Nursing Home Limited is the registered provider for Glengara Park Nursing Home. The person in charge reports to the group quality and clinical practice lead, who in turn reports to the group director of operation. The clinical management team consisted of a person in charge, an assistant director of Nursing and two clinical nurse managers (CNM). The person in charge also has oversight of a team of nurses and healthcare staff, activity staff, chefs, a catering and domestic team, administration, and maintenance staff.

There were sufficient staff on duty across all areas of the centre, to meet the assessed needs of the residents. The person in charge, assistant director of nursing and clinical nurse manager, worked in a wholly supernumerary capacity, providing daily clinical and operational support to the staff. New health care assistant staff were currently receiving an induction training for their roles, and the provider was actively recruiting for an activities staff member and a chef.

There was an ongoing schedule of training in the centre. A suite of mandatory training was available to all staff at the centre, and the training was up to date. There was a high level of staff attendance at training in areas such as safeguarding, fire safety, behaviours that are challenging, manual handling, and infection prevention and control. Staff with whom the inspectors spoke were knowledgeable regarding infection prevention and control and safeguarding procedures.

The inspectors reviewed records of governance meetings and staff meetings that had taken place since the previous inspection. Governance meetings took place each month, and staff meetings took place quarterly in the centre. Weekly senior management updates were completed by the person in charge and reviewed by senior management. The person in charge completed a key performance indicator (KPI) report, which was discussed with the regional operations manager. A detailed annual review for 2025 was available, and it outlined the improvements completed in 2025 and the improvement plans for 2026. Inspectors reviewed the results of audits carried out in the centre since the previous inspection, including audits of falls, call-bell response times, infection prevention and control processes and medication management practices. While audits had been completed, the findings from some audits did not form a quality improvement plan to address identified issues. This is discussed under Regulation 23: Governance and management.

The inspectors reviewed the records of complaints raised by residents and relatives and found they were appropriately managed. Residents who spoke with the inspectors were aware of how to make a complaint and to whom a complaint could be made.

Regulation 15: Staffing

The registered provider had arrangements in place to ensure that appropriate numbers of skilled staff were available to meet the assessed needs of the 63 residents living in the centre on the day of the inspection.

Recruitment was in progress for an activities role and a chef. Two health care assistants and a housekeeper had been hired at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

A review of staff training documentation confirmed that all staff working in the designated centre were up-to-date with their mandatory training. This included training in fire safety, which was provided on an annual basis, while training in manual handling and safeguarding was provided in accordance with the designated centre's policies.

Judgment: Compliant

Regulation 23: Governance and management

While the provider had management systems to monitor the quality and safety of service provision, these oversight systems were not fully effective to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. For example:

- A number of the centre's audit records did not consistently identify areas for improvement, or had a plan for how the improvement was to be achieved and sustained.
- The systems in place to ensure oversight of the use of restraint did not fully ensure that, where restraint was used, it was used in accordance with the national policy. This is outlined further under Regulation 7: Managing behaviour that is challenging.
- Inspectors found that a number of fire safety risks identified through the provider's own systems were not yet addressed and continue to pose a fire safety risk in the centre.
- There was inadequate oversight of residents' mealtimes experience in the centre, and the nutritional needs of residents were not adequately met. This is outlined under Regulation 18: Food and nutrition.
- The management systems in place did not recognise or address the issues identified by inspectors, as presented under regulations on infection control, premises, and assessment and care plans.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the registered provider of the centre. These clearly outlined the room the resident occupied and additional charges, if any.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider provided an accessible and effective procedure for dealing with complaints, which included a review process. The required time lines for the investigation into and review of complaints were specified in the procedure. The procedure was prominently displayed in the centre.

The complaints procedure also provided details of the nominated complaints and review officer. These nominated persons had received suitable training to deal with complaints. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service.

Judgment: Compliant

Quality and safety

Residents who could express a view were satisfied with the quality of the care they received, and the inspectors observed some pleasant engagement between staff and residents throughout the inspection. Notwithstanding these positive findings, the inspectors found that the premises, infection control, food and nutrition, assessment and care planning and the management of responsive behaviours and fire precautions did not fully align with the requirements of the regulations and the centre's own policy.

Overall, the premises were designed and laid out to meet the needs of the residents. Bedrooms were personalised, and residents had space for their belongings. The general environment, including residents' bedrooms, communal areas and toilets, appeared visibly clean. However, works were required to attend to areas of wear and tear throughout the centre, storage of equipment and the cleanliness of the kitchenette on the first floor. This is discussed under Regulation 17: Premises.

A choice of meals and snacks was offered to all residents. A daily menu was available for residents in the dining rooms. Residents on modified diets received the correct consistency meals and drinks. The dining experience observed on all floors was relaxed. Inspectors found that the dining experience for residents, especially during breakfast in their bedrooms, did not support their nutritional needs. This is discussed further under Regulation 18: Food and nutrition.

While the registered provider had ensured staff were trained in fire prevention and emergency procedures, they did not address outstanding fire safety issues identified in their own management systems. This is discussed further under Regulation 28: Fire precautions.

The inspectors reviewed a sample of residents' nursing notes and care plans. The inspectors viewed a sample of residents' safeguarding care plans and the management of behaviours that are challenging care plans, which were person-centred and outlined specific interventions to safeguard the residents. However, inspectors found that not all residents had care plans developed according to their needs, and this is outlined under Regulation 5: Individual assessment and care plan.

There was a policy in place to inform management of 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). There was evidence that staff had received training in responsive behaviours. Residents had access to psychiatry of later life. For residents with identified responsive behaviours, nursing staff had identified the trigger causing this behaviour using a validated antecedent-behaviour-consequence (ABC) tool. There were clear care plans for the management of the residents' responsive behaviour. It was evident that the care plans were being implemented.

There was open access to the centre’s internal courtyards, and residents enjoyed accessing this space when the weather allowed. The centre maintained a restrictive practice register, and staff had access to a local restrictive practice guideline. The restrictive practice register identified that 25 of the 63 residents living in the centre were using bed rails. However, inspectors found that the implementation and documentation of restrictive practice was not in line with best practice as set out in the national guidance on restrictive practice. This is discussed further under Regulation 7: Managing behaviour that is challenging.

All staff had An Garda Síochána (police) vetting disclosures on file. Staff had completed bespoke safeguarding training. Staff spoken with were clear about their role in protecting residents from abuse. The provider did not act as a pension agent for any residents. The provider had a transparent system in place where all lodgements and withdrawals of residents' personal monies were signed by two staff members and logged. The records reviewed showed incidents and allegations of abuse had been investigated in accordance with the provider's policy.

Regulation 12: Personal possessions

Residents were supported in accessing and retaining control over their personal property and possessions. Residents had ample space to store and maintain their clothing and possessions. Residents had access to lockable storage facilities in their bedrooms for valuables. The centre had an on-site laundry for laundering residents' clothing. Residents were complimentary about the laundry service received in the centre.

Judgment: Compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in Schedule 6 of the regulations, for example;

- There were some areas that showed wear and tear: for example, walls, skirting boards, and architraves in some residents' bedrooms had marked damage, which appeared to have been caused by manual handling procedures and by residents mobilising in adaptive wheelchairs due to a lack of space.
- Patio slabs in the outdoor garden area were uneven, potentially posing a risk of trips and falls to residents.
- The storage of equipment was inappropriate in communal bathrooms; for example, in one bathroom, inspectors observed one unused trolley, 5 commodes and a zimmer frame stored.
- A review of the radiator covers in the centre was required as some were damaged and worn.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' meals were not appropriately served, offered a choice and residents were not always adequately supported with their nutritional needs. This was evidenced by the following:

- Residents who chose to have their breakfast in their bedrooms did not have their food served appropriately. For example, inspectors observed untouched breakfast trays in rooms of residents who required assistance with their meals, and the food had gone cold. Staff were alerted to this by inspectors.
- Staff were observed placing food protectors on residents during a mealtime experience. Staff did not engage in conversation with residents as to whether it was their preference to wear a food protector.

- Throughout the day of inspection, it was observed that all residents were given plastic mugs and glasses to drink their hot or cold beverages. Residents were not afforded a choice to drink from a regular or ceramic mug, leading to a process of routine practices for all residents. This practice also did not support an enjoyable mealtime experience.

Judgment: Not compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre had a risk management policy, which contained appropriate guidance on the identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection Control and the National Standards for Infection Prevention and Control in Community Services (2018); however, further action in respect of the management of the environment and equipment was required to be fully compliant. For example;

- The kitchenette on the first floor was observed to be unclean on the morning of inspection. Spillage of fruit juice and from other foods was seen in the fridge. The freezer compartment was completely frozen over, and the freezer door could not close correctly as a result. The microwave in this area was also observed to be unclean, and remnants of food were visible inside.
- A number of shower drains were found to be unclean on the day of inspection.
- A review of the radiator covers in the centre was required as some were damaged and worn.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider has identified in the minutes of their clinical governance meetings a number of fire-related issues;

- A fire door needs replacement. This fire door near the laundry on the lower ground floor is quoted as "not fit for its purpose" and that staff are to use "an alternative fire door in the event of evacuation ".
- A risk of the fire door panel not releasing during evacuation and an ongoing fault on the fire panel.
- External evacuation stairwell front of centre "rusty and tearing down".

These items have been on the agenda for a prolonged period and do not appear to be addressed in a timely manner. This lack of action continues to pose a fire safety risk for residents and staff working in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans were not always developed following a comprehensive assessment of need. For example;

- Residents who were prescribed and were receiving oxygen therapy did not have a care plan developed to meet their needs.
- In addition, a resident whose care plan outlined treatment for a grade two pressure sore did not have their care plan updated as the pressure sore had healed.

A sample of care plans reviewed was not all formally reviewed on a four-monthly basis to ensure care was appropriate to the resident's changing needs.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Where restraint was used in the centre, it was not always used in accordance with the national policy. On a review of records, there was no evidence that less restrictive measures were trialled before a restrictive practice was implemented. In addition, upon reviewing the safety check records, the inspectors noted that these were not consistently carried out hourly as required by the provider's policy.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider took all reasonable measures to protect residents from the risk of abuse. For example;

- An updated safeguarding policy was in place. Staff members spoken with demonstrated knowledge about what constitutes abuse and the appropriate actions to take if an allegation of abuse is made.
- The person in charge investigated all allegations of abuse, making appropriate referrals to external agencies where required.
  Prior to commencing employment in the centre, all staff were subject to Garda Síochána (police) vetting.
- The registered provider was not a pension agent for any residents. There were appropriate systems in place for the management of residents' personal money.
- The registered provider facilitated staff to attend regular training in the safeguarding of vulnerable persons.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, residents' right to privacy and dignity were well respected. Residents were afforded choice in their daily routines and had access to individual copies of local newspapers, radios, telephones and television. Independent advocacy services were available to residents, and the contact details for these were on display. There was evidence that residents were consulted with and participated in the organisation of the centre, and this was confirmed by residents' meeting minutes, satisfaction surveys, and speaking with residents on the day.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Glengara Park Nursing Home OSV-0000044

Inspection ID: MON-0049628

Date of inspection: 21/04/2026

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Clinical audit will be completed as per schedule via an electronic system tool. All identified issues and corresponding action plans will be documented on additional audit log form to accurately reflect the audit findings, identified concerns, and comprehensive improvement actions. The audit results and Quality Improvement Plan will be discussed at the quarterly Clinical Governance Meeting and monthly Unit Meetings. The audit findings and action plans will also be shared with the nursing team and relevant departments. Any identified risks and key learning points will be communicated through daily Safety Huddles and departmental meetings to ensure awareness, promote continuous improvement, and support ongoing compliance with quality and safety standards. • The pre-admission assessment procedure and associated documentation are currently under review to ensure they reflect best practice and support informed decision-making regarding the use of restrictive practices. The use of restraints will be discussed with residents and their nominated representatives prior to admission to Glengara Park. A comprehensive risk assessment will be completed on admission, and trials of alternative measures will be initiated where appropriate, in accordance with the resident's assessed needs, preferences, choices, and rights. Glengara Park will continue to promote a culture of positive risk-taking, supporting residents to maintain their independence, autonomy, and quality of life while ensuring their safety and wellbeing. The use of restraints will be included as a standing agenda item at Residents' Forum meetings to provide ongoing education, information, and opportunities for discussion. This will support residents in understanding restrictive practices and encourage their participation in decision-making. The Multidisciplinary Team (MDT) will continue to review restrictive practices on a quarterly basis, or sooner if a resident's needs or circumstances change, to ensure that any restrictions remain necessary, proportionate, and in the resident's best interests. Nursing staff will continue to review care plans regularly and ensure that all restraint reduction trials and their outcomes are clearly documented in each resident's care plan.	

PIC discussed the finding of the inspection with the nursing team. Safety checks records are now being done hourly. PIC, ADON and CNM will oversee the completion of the safety checks on a daily basis.
• An independent contractor has been engaged to carry out a review of the fire door near the laundry. Once the report is received the required works will be completed.
• A review of the fire door panels is being caried out. Any work required will be addressed and completed. The fire panel was serviced, and all faults are now gone off the system.
• The rusty part of the stairwell will be repaired or replaced where required.

• A review of the meal service is currently underway. Procurement of the required equipment to support these changes is in progress. PIC met with the Catering staff and Nursing staff and discussed that food should only be offered when the residents are ready and to ensure assistance timely when required. PIC, ADON and CNM on duty are overseeing resident' s mealtime experience. PIC will continue to complete meal time audit and shared the result via safety huddle. Staff will continue to ask residents whether they require a clothing protector at mealtimes and will respect each resident's individual choice. The management team will continue to oversee mealtime practices to ensure residents receive a dignified, person-centred
• Dining experience. Areas requiring improvement will be identified through ongoing observation, audits, and feedback. Findings and actions will be discussed at staff meetings and during daily Safety Huddles to support continuous quality improvement. The use of polycarbonate mugs during snack rounds has been reviewed. These have been removed from the snack trolley and replaced with ceramic mugs. Alternative drinking vessels will only be offered where this is in line with the resident's assessed needs, preferences, and choices, and this will be clearly documented in the resident's Nutrition Care Plan. Polycarbonate cups have also been reviewed and replaced with glassware where appropriate.
• The cleaning records have been reviewed and updated to include a more robust cleaning schedule for the kitchenette. This schedule now incorporates the daily cleaning of all appliances and surfaces. Compliance with kitchenette cleaning requirements is also monitored through the revised Health and Safety Walkaround Tool. A meeting was held with the housekeeping team following the inspection to discuss the findings and reinforce cleaning standards. The Person in Charge (PIC) will oversee the completion and monitoring of the cleaning schedules to ensure ongoing compliance. Bathroom cleaning compliance has also been incorporated into the Health and Safety Walkaround Tool. In addition, environmental audits will be completed on a monthly basis, and a Clinical Governance Walkaround will be conducted weekly to monitor environmental standards and identify areas for improvement. The PIC will arrange additional housekeeping training to support staff learning needs, reinforce best practice, and ensure continued compliance with Infection Prevention and Control (IPC) standards. Maintenance personnel are currently carrying out painting and touch-up work on radiators throughout the Centre. The PIC will oversee the progress and completion of these maintenance works on a daily basis to ensure they are completed to the required standard. In addition, an external contractor has been engaged to repaint the communal areas. Staff will continue to log all maintenance requests through an electronic system tool. Outstanding maintenance tasks will be reviewed on a daily basis to ensure timely completion and appropriate follow-up. Management will continue to monitor the environment through regular audits and walkabouts to identify any areas requiring

improvement and to ensure a safe, clean, and well-maintained environment for residents, visitors, and staff. The patio slabs in the outdoor patio area were reviewed following the inspection. The uneven surfaces identified have since been levelled and repaired by the maintenance team to reduce the risk of trips and falls. Following the inspection, the Person in Charge (PIC) reviewed all storage areas within the home. Any inappropriate equipment stored in communal bathrooms was removed and relocated to designated storage areas. Staff have been informed of these changes during Safety Huddles and clear signage has been put in place to support compliance. Maintenance personnel are currently undertaking repainting and touch-up work on radiators and walls throughout the centre. In addition, an external contractor has been engaged to repaint the communal areas.
Resident Oxygen care plan has been updated following the inspection. Care planning training is available to all nurses through a online learning platform. All nursing staff have been instructed to retake the Care Planning Training module to reinforce best practice and ensure consistency in documentation. As part of the Quality Improvement Plan, face-to-face Care Planning Workshops have been introduced to provide additional support, guidance, and opportunities for discussion. In addition, weekly "Buzz Sessions" are now being held to promote continuous learning and address any care planning queries or challenges. Residents skin integrity care plan has been updated following the inspection. The Person in Charge (PIC) has met with the nurses and instructed to ensure that care plans are regularly updated using the Care Evaluation section and that comprehensive reviews are completed at least every four months, or sooner where there is a change in the resident's condition, needs, preferences, or circumstances. The PIC will continue to maintain oversight of care plans, care plan evaluations, and resident assessments on a daily basis. Any areas identified as requiring improvement will be discussed during daily Safety Huddles and addressed through scheduled Care Planning Education Sessions to promote high-quality, person-centred care and ensure compliance with regulatory requirements

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Staff will continue to log all maintenance requests through an electronic system tool. Outstanding maintenance tasks will be reviewed on a daily basis to ensure timely completion and appropriate follow-up. Management will continue to monitor the environment through regular audits and walkabouts to identify any areas requiring improvement and to ensure a safe, clean, and well-maintained environment for residents, visitors, and staff.
• The patio slabs in the outdoor patio area were reviewed following the inspection. The uneven surfaces identified have since been levelled and repaired by the maintenance team to reduce the risk of trips and falls.
• Following the inspection, the Person in Charge (PIC) reviewed all storage areas within the home. Any inappropriate equipment stored in communal bathrooms was removed

and relocated to designated storage areas. Staff have been informed of these changes during Safety Huddles and clear signage has been put in place to support compliance.
• Maintenance personnel are currently undertaking repainting and touch-up work on radiators and walls throughout the centre. In addition, an external contractor has been engaged to repaint the communal areas.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• A review of the mealtime service is currently underway, and procurement of the required equipment to support these improvements is in progress. The PIC met with catering and nursing staff to reinforce that meals should only be served when residents are ready and that timely assistance should be provided when required. The PIC, ADON, and CNM on duty continue to oversee residents' mealtime experiences. The PIC will continue to complete mealtime audits and share the findings with staff through the safety huddle process.
• Staff will continue to ask residents whether they require a clothing protector at mealtimes and will respect each resident's individual choice. The management team will continue to oversee mealtime practices to ensure residents receive a dignified, person-centered dining experience. Areas requiring improvement will be identified through ongoing observation, audits, and feedback. Findings and actions will be discussed at staff meetings and during daily Safety Huddles to support continuous quality improvement.
• The use of polycarbonate mugs during snack rounds has been reviewed. These have been removed from the snack trolley and replaced with ceramic mugs. Alternative drinking vessels will only be offered where this is in line with the resident's assessed needs, preferences, and choices, and this will be clearly documented in the resident's Nutrition Care Plan. Polycarbonate cups have also been reviewed and replaced with glassware where appropriate.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• The cleaning records have been reviewed and updated to include a more robust cleaning schedule for the kitchenette. This schedule now incorporates the daily cleaning of all appliances and surfaces. Compliance with kitchenette cleaning requirements is also monitored through the revised Health and Safety Walkaround Tool. A meeting was held with the housekeeping team following the inspection to discuss the findings and reinforce cleaning standards. The Person in Charge (PIC) will oversee the completion and monitoring of the cleaning schedules to ensure ongoing compliance.

• Bathroom cleaning compliance has also been incorporated into the Health and Safety Walkaround Tool. In addition, environmental audits will be completed on a monthly basis, and a Clinical Governance Walkaround will be conducted weekly to monitor environmental standards and identify areas for improvement. The PIC will arrange additional housekeeping training to support staff learning needs, reinforce best practice, and ensure continued compliance with Infection Prevention and Control (IPC) standards.

• Maintenance personnel are currently carrying out painting and touch-up work on radiators throughout the Centre. The PIC will oversee the progress and completion of these maintenance works on a daily basis to ensure they are completed to the required standard. In addition, an external contractor has been engaged to repaint the communal areas.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• An independent contractor has been engaged to carry out a review of the fire door near the laundry. Once the report is received the required works will be completed.

• A review of the fire door panels is being caried out. Any work required will be addressed and completed. The fire panel was serviced, and all faults are now gone off the system.

• The rusty part of the stairwell will be repaired or replaced where required.

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:

• Resident Oxygen care plan has been updated following the inspection. Care planning training is available to all nurses through a learning platform. All nursing staff have been instructed to retake the Care Planning Training module to reinforce best practice and ensure consistency in documentation. As part of the Quality Improvement Plan, face-to-face Care Planning Workshops have been introduced to provide additional support, guidance, and opportunities for discussion. In addition, weekly "Buzz Sessions" are now being held to promote continuous learning and address any care planning queries or challenges.
Residents skin integrity care plan has been updated following the inspection. The Person in Charge (PIC) has met with the nurses and instructed to ensure that care plans are regularly updated using the Care Evaluation section and that comprehensive reviews are completed at least every four months, or sooner where there is a change in the resident's condition, needs, preferences, or circumstances. The PIC will continue to maintain oversight of care plans, care plan evaluations, and resident assessments on a daily basis. Any areas identified as requiring improvement will be discussed during daily Safety Huddles and addressed through scheduled Care Planning Education Sessions to promote high-quality, person-centred care and ensure compliance with regulatory requirements

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• The pre-admission assessment procedure and associated documentation are currently under review to ensure they reflect best practice and support informed decision-making regarding the use of restrictive practices. The use of restraints will be discussed with residents and their nominated representatives prior to admission to Glengara Park. A comprehensive risk assessment will be completed on admission, and trials of alternative measures will be initiated where appropriate, in accordance with the resident's assessed needs, preferences, choices, and rights. Glengara Park will continue to promote a culture of positive risk-taking, supporting residents to maintain their independence, autonomy, and quality of life while ensuring their safety and wellbeing. The use of restraints will be included as a standing agenda item at Residents' Forum meetings to provide ongoing education, information, and opportunities for discussion. This will support residents in

understanding restrictive practices and encourage their participation in decision-making. The Multidisciplinary Team (MDT) will continue to review restrictive practices on a quarterly basis, or sooner if a resident's needs or circumstances change, to ensure that any restrictions remain necessary, proportionate, and in the resident's best interests. Nursing staff will continue to review care plans regularly and ensure that all restraint reduction trials and their outcomes are clearly documented in each resident's care plan.
• PIC discussed the finding of the inspection with the nursing team. Safety checks records are now being done hourly. PIC, ADON and CNM will oversee the completion of the safety checks on a daily basis.

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.	Substantially Compliant	Yellow	31/08/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	30/07/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	30/07/2026
Regulation 23(1)(d)	The registered provider shall ensure that	Not Compliant	Orange	31/10/2026

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	30/07/2026
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.	Substantially Compliant	Yellow	31/10/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/10/2026
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	Substantially Compliant	Yellow	30/07/2026

	designated centre concerned.			
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	30/07/2026
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/07/2026