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:	Lakes Nursing Home
Name of provider:	Elder Nursing Homes Ltd
Address of centre:	Hill Road, Killaloe, Clare
Type of inspection:	Unannounced
Date of inspection:	09 March 2026
Centre ID:	OSV-0000447
Fieldwork ID:	MON-0047499

About the designated centre

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

Lakes Nursing Home is a two-storey purpose-built centre designed to provide care for residents requiring continuing and short stay care including respite and convalescence. As a provider of high quality nursing care, we welcome the 'National Standards for Residential Care Settings for Older People in Ireland'. These standards will help to consolidate existing good practice whilst also identifying areas for development. We are committed to enhancing the quality of life of all our residents by providing inclusive, high-quality, resident-focused 24-hour nursing care, catering, service and activities. Lakes Nursing Home can accommodate a maximum of 57 residents. There are 47 single rooms available with en-suite toilet facilities as well as five double rooms with en-suite toilet facilities. A number of shared shower rooms are available. There is stairs and lift access to the first floor. It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care for persons with learning, physical and psychological needs can also be met within the unit. Care is provided for people with a range of needs: low, medium, high and maximum dependency. We employ a professional staff consisting of registered nurses, care assistants, maintenance, and laundry, housekeeping and catering staff. Prior to admission, a pre-admission assessment shall be undertaken in the resident's home or transferring facility, by a member of the residential home's nursing staff. Care plans will be established and reviewed through inclusion of families and residents supported by the community services on referral. Resident records are stored on a secure computer system and also in filing cabinets. The activities coordinator meets new residents to plan an individual activities programme. Residents are encouraged to keep up their social/leisure interests after admission, for example, gardening, painting, knitting, quiz, music, media access, beauty and hair therapy. Day trips are also organised occasionally. Arrangements can be made for residents to go shopping or attend other activities outside the nursing home; these may incur some extra costs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

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
Monday 9 March 2026	08:50hrs to 17:10hrs	Rachel Seoighthe	Lead
Monday 9 March 2026	08:50hrs to 17:10hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

This unannounced inspection was conducted over one day. There were 55 residents living in the centre, and two vacancies.

Inspectors observed that residents were supported to enjoy a satisfactory quality of life in the centre. Inspectors heard some positive comments and several residents informed inspectors that they were 'very happy' living in the centre. A number of residents expressed individual concerns around certain aspects of the service. However, the majority of residents were complimentary about the staff and the quality of the service provided.

Inspectors were greeted by a member of staff on arrival to the centre. Following an introductory meeting with the person in charge, inspectors walked around the centre, giving an opportunity to review the living environment, and meet with residents and staff.

Located in a residential area in Killaloe, County Clare, the Lakes Nursing Home is registered to accommodate up to 57 residents. The designated centre was a purpose built, two-storey building, with stairs and passenger lift access between floors.

Resident bedroom accomodation consisted of single and twin bedrooms which were laid out over both floors. Many residents bedrooms were decorated with personal memorabilia, such as photographs and soft furnishings. Televisions and call bells were provided in all bedrooms. Inspectors observed that residents had access to storage facilities for their personal possessions. One resident was eager to show inspectors their collection of photographs, artwork and musical instruments.

There were a variety of communal spaces in the centre, including several sitting rooms and a dining room. Residents had unrestricted access to an enclosed garden, which was also the location for the centres' designated smoking area. Inspectors observed that the garden was in regular use throughout the day of the inspection. However, inspectors noted that there was an odour of cigarette smoke in some areas of the centre. Inspectors spoke with one resident who preferred to smoke at an exit door leading to the enclosed garden. They informed inspectors that they did not like to smoke outside as it was ' too cold', and there was not adequate heating provided in the designated smoking area.

In the morning of the inspection, inspectors noted that the atmosphere in the centre was relaxed. Some residents were observed having breakfast in the dining room on the ground floor. A number of residents were in their bedrooms, receiving support with personal care. Inspectors noted that the communal sitting room on the ground floor was busy throughout the day, as residents activities were taking place, and visitors were coming and going. This area was supervised by staff, who were

observed engaging with residents in a kind manner. An activity schedule was displayed, and designated staff were assigned to facilitate activities. Residents who chose to remain in their bedrooms were supported in doing so, and were observed to be supervised throughout the day. Residents reported that there was sufficient activity available. On the afternoon of the inspection, residents' enjoyed a tea party, which was held in celebration of international women's day.

Inspectors spoke with many residents and a small number of visitors. Feedback from a number of residents was positive. One resident told inspectors that they had been living in the centre for many years, and they 'loved' their life centre, while another resident described being 'very happy' in centre and feeling 'appreciated'. However, a small number of residents described occasions where their rights were not upheld and they were not appropriately safeguarded. One resident described challenges in communicating with staff, regarding their health care needs.

The provider had taken some action to address deficits in respect of the care environment since the previous inspection. For example, circulating corridor floors were replaced and floor covering had been replaced in a number of resident bedrooms and ensuite bathrooms. The house-keeping facilities had also been enhanced since the previous inspection. However, inspectors noted that some areas of the centre were in a poor state of repair and the replacement of flooring was not fully complete at the time of inspection.

Information regarding advocacy services was displayed throughout the centre, and inspectors were informed that residents were supported to access this service, if required.

Visitors were observed being welcomed into the centre throughout the inspection. Residents met with their friends and loved ones in their bedrooms or communal rooms.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre and describes how these arrangements support the quality and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations.

Capacity and capability

This was an unannounced inspection conducted by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended), and to follow up on the findings of the previous inspection in April 2025, which identified non compliance in relations to premises, infection control, and governance and management. This inspection identified repeated deficits in relation to the premises, and therefore, the care environment did not achieve full compliance with the

regulations. This inspection also found that management monitoring systems in place to monitor the quality of the service provided to residents were ineffective, and the registered provider failed to demonstrate sustained compliance with assessment and care planning, protection, training and development of staff, records, notification of incidents and the complaints procedure.

A restrictive condition was attached to the registration of the centre in March 2024, requiring that works to the premises were to be completed by 31 July 2024, to ensure that the centre was maintained in a good state of repair, and to ensure that the care environment was safe and suitable for resident needs. The most recent inspection of the centre in April 2025, found that the provider had not fully met this condition of registration. The provider subsequently applied to extend the condition date to 31 July 2025, to facilitate the completion of repair and maintenance works. However, this inspection found that, although the provider had made a number of enhancements to the premises, repair works were incomplete in some areas, and the care environment was not in line with regulatory requirements.

The centre was operated by Elder Nursing Homes Ltd who are the registered provider for the Lakes Nursing Home. Mowlam Nursing Homes Limited are participating in the management of the service. A director of care services and a regional healthcare manager provide operational oversight and support to the local management team. Changes had occurred to the local management team since the previous inspection, through the appointment of new clinical nurse manager, and the return of the person in charge from a period of extended leave. A team of nurses, care assistants, activities, catering, maintenance and domestic staff made up the staffing compliment. The clinical nurse manager deputised in the absence of the person in charge.

At the time of the inspection there were vacancies for six full-time health care assistants. Records demonstrated that recruitment was ongoing to fill these posts. Agency staff were used to supplement the roster on a daily basis. Inspectors found that the staffing number and skill mix on the day of inspection were appropriate to meet the care needs of the residents.

Staff had access to education and training, and records demonstrated that a training schedule was in place. Staff had completed mandatory training in topics including fire safety, safeguarding of vulnerable people and patient moving and handling techniques. However, inspectors found that there was ineffective supervision of resident care planning, to ensure that residents care needs were adequately met. This is detailed further under Regulation 16: Training and development.

Some of the management systems in place did not ensure that the service was consistent or effectively monitored. There was a programme of auditing in clinical care and environmental safety, to support the management team to measure the quality of care provided to residents. However, a scheduled monthly audit of wound management had not been completed in February 2026. Consequently, deficits in wound care planning documentation and implementation, as seen on inspection, had not been identified by the management team. A safeguarding audit completed in February 2026, achieved 98% compliance in the management of safeguarding.

However, a review of resident progress notes found that some safeguarding incidents were not identified, recorded appropriately, or investigated by the management team. Furthermore, the Chief Inspector had not been notified of a number of safeguarding allegations, as required by the regulations. This was a repeated non-compliance. In addition, the management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner.

Record management systems consisted of both a paper-based and electronic system. Staff files contained the necessary information, as required by Schedule 2 of the regulations, including evidence of a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. However, some records were not appropriately maintained. For example, documentation and investigation of an incident in which a resident may have suffered potential abuse or harm was not completed in line with Schedule 3 (4)(j) of the regulations.

An annual report on the quality of the service had been completed for 2025 which had been done in consultation with residents and set out the service's level of compliance as assessed by the management team.

Regulation 15: Staffing

There was sufficient staff on duty with appropriate skill mix to meet the needs of the current residents, taking into account the size and layout of the designated centre. A review of the staffing rosters found that there were adequate numbers of suitably qualified staff available to support residents' assessed needs.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised. This was evidenced by;

- poor supervision of the development, review and implementation of resident care plan documentation.
- failure to identify potential safeguarding incidents to ensure appropriate management, documentation and notification of these incidents.

Judgment: Substantially compliant

Regulation 21: Records

Record management was not in line with the requirements of the regulations. This was evidenced by;

- Records of nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of fluid intake and output were not maintained in line with residents' nutritional care plans. This impacted on monitoring of residents with clinical risks.
- Some records of adverse incidents involving residents did not contain all the information required under Schedule 3(4)(j) of the regulations. For example, there was no results of investigations, learning, or action taken in response to several potential safeguarding incidents.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to ensure that there were sufficient staffing resources in place to consistently maintain planned staffing levels, in line with the current resident care needs and the centre's statement of purpose. For example, at the time of inspection, there were vacancies for for six full-time health care assistants, and a high level of dependency on agency staff.

The management systems in place to monitor the quality of the service were not fully effective to ensure the service provided to residents was effectively monitored. For example;

- the systems in place to manage complaints was not effective. Where complaints regarding the quality of the service had been made, the complaints were not always recorded, investigated, and responded to. Records demonstrated that there were complaints recorded in resident progress notes, and in resident meeting minutes, that had not been managed in line with the centres complaints procedure.
- the oversight and monitoring of adverse incidents involving residents was not effective, to ensure they were appropriately recorded, reported, investigated and notified to the Chief Inspector, as required.
- there was ineffective management oversight of the residents clinical documentation, including the assessment of residents needs and care plans.

The provider had breached a condition of registration by failing to ensure that the premises were in a good state of repair. This is a repeated finding.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not notified the Chief Inspector of a number of safeguarding allegations, within the required time frames, as stipulated in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were not recorded and managed in line with the centre's own policy and the requirements of the regulation. For example, records showed that not all complaints or expressions of dissatisfaction with the service had been investigated and therefore there was no plan in place to address the issues of concern. In addition, inspectors were informed by a resident that they had recently communicated a complaint to staff in the centre. This was confirmed by the person in charge, however the complaint was not recorded.

Judgment: Not compliant

Regulation 22: Insurance

The provider had an up-to-date contract of insurance in place against injury to residents, and loss or damage to residents' property.

Judgment: Compliant

Quality and safety

Residents living in the centre were generally satisfied with the quality of the service they received. Inspectors observed staff engaging with residents in a respectful manner. However, this inspection found that assessment and care planning, and protection did not meet the requirements of the regulations. Furthermore, although the provider had completed some works to enhance the care environment, including the provision of new floor covering, repair works were incomplete in some areas.

The care environment was not in line with regulatory requirements and the provider was breach of a condition of registration.

The centre had an electronic resident care record system. Pre-admission assessments were undertaken by the person in charge to ensure that the centre could provide appropriate care and services to persons being admitted. A number of validated nursing tools were used to assess residents' care needs. Residents' care plans and daily nursing notes were recorded on an electronic documentation system. A sample of assessments and care plans were reviewed and found that care plans were not consistently developed following an assessment of need, and care plans were not always implemented effectively. For example, a resident with pressure related injuries did not receive care in line with the interventions recorded in their wound care plan. Furthermore, several behavioural support care plans were not updated following incidents of responsive behaviours which had a potential impact on the safety of other residents.

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided support and guidance in recognising and responding to allegations of abuse. However, records of investigation of several safeguarding allegations were not available on the day of inspection. This is detailed under Regulation 8: Protection.

The provider had taken some action to enhance the physical environment including the provision of new floor covering along circulating corridors, bedrooms and ensuite toilets. However, repeated issues were identified in relation to some areas of the areas of residents' living environment, which were not maintained to a good standard. These observations included scuff marks and chipped paint on a number of wall surfaces and damaged floor covering in resident ensuite toilets and bedrooms. Furthermore, there was insufficient storage space in the designated centre. This is detailed under Regulation 17: Premises.

Records demonstrated that there were referral systems in place, and residents had access to, health and social care professionals, such as dietitian services. Residents had timely access to medical treatment by their General Practitioners.

Visitors were observed attending the centre throughout the day of the inspection. Inspectors saw that residents could receive visitors in their bedrooms or in a number of communal rooms.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found be unrestricted, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 17: Premises

The registered provider failed to ensure that the premises conformed to the matters set out in Schedule 6 of the regulations, or in the condition of the centre's registration. For example:

- wall surfaces in some resident bedrooms and communal areas were marked and damaged.
- wall paper was lifting along some corridor walls.
- floor covering in some resident ensuites toilets and bedrooms was in a poor state of repair.
- there was inadequate ventilation in a resident assisted toilet on the ground floor.
- the floor covering leading to the designated external smoking area was damaged.

There was a lack of suitable storage in the centre. This was evidenced by the following:

- Large supplies of incontinence wear were being stored in a residents' external recreational area.
  The storage of a supply of shower chairs in a resident assisted bathroom.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that the registered provider did not ensure the assessed needs of residents were consistently met, in line with their individual care plans. For example:

- A resident with pressure related injuries was not referred for an appropriate seating assessment. The resident was nursed in bed on a continuous basis, as there was no alternative arrangement available, such as specialist seating.
- Recommendations received from a tissue viability nurse specialist in relation to the measures required to prevent further deterioration of a residents' pressure related injuries, including the provision of a specific item of equipment and wound dressing products, was not implemented at the time of inspection.

Care plans were not developed in a timely manner, in line with the known care needs of a resident. For example:

- a resident with a pressure related injury did not have care plan to support wound management and prevention.
- a resident with an assessed need for pain relief, did not have a care plan developed directing on the cause and location of the pain, and the interventions required to alleviate the pain.

Care plans were not reviewed or updated when a resident's condition changed. For example:

- care plans to support two residents' increased monitoring, supervision and behavioural support needs had not been reviewed or updated following a number of incidents that had occurred in the centre. Consequently, staff did not have the required information to support the resident's assessed needs.
- A resident care plan was not updated to demonstrate why a resident was under the care of a specific allied health service, the rationale for their discharge from that service, and the residents' personal preference in relation to this arrangement.

Judgment: Not compliant

Regulation 6: Health care

A review of a sample of residents' files found that residents' health care needs were regularly reviewed by their general practitioner (GP). Residents were supported to access allied health care professionals including a physiotherapist, dietitian, and a speech and language therapist.

Judgment: Compliant

Regulation 8: Protection

The registered provider had not taken all reasonable measures to protect residents from abuse, and to provide for appropriate and effective safeguards to prevent abuse. Records of preliminary screening investigations were not completed following allegations made regarding several adverse incidents, to rule out any potential safeguarding concerns.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 22: Insurance	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Lakes Nursing Home OSV-0000447

Inspection ID: MON-0047499

Date of inspection: 09/03/2026

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 16: Training and staff development	Substantially Compliant

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

• The Person in Charge (PIC), supported by the Clinical Nurse Manager (CNM), will ensure that all staff are appropriately supervised, guided and directed in the fulfilment of their roles and responsibilities.

• The PIC will provide training to all Nurses on care plan development, and this bespoke training module is available on the online Learning & Development platform. All nurses will receive training on writing a plan of care that incorporates What Matters to the individual resident, in accordance with the implementation of an Age-Friendly Health System. Following completion of training, the PIC and CNM will oversee the development, review and implementation of resident care plan documentation to ensure that this is person-centred and accurately reflects each resident's assessed care needs, and that residents and their designated representatives are consulted so that the plan of care reflects the residents' preferences and choices.

• The PIC / Clinical Nurse Manager (CNM) will ensure there is consistent oversight of the development, implementation and review of care plans, and nurse will be supported through the care planning process. They will have regular reflective practice meetings with the PIC and/or CNM to evaluate the quality of their care records.

• The PIC will ensure that all incidents and progress notes are reviewed weekly, and that any potential safeguarding concerns are managed in line with Mowlam policy and notified to the authority as required. In addition, the PIC will ensure that incidents are discussed as part of the monthly management meeting and a Quality Improvement plan will be developed as necessary.

• The Healthcare Manager, Quality and Safety will conduct Safeguarding and Complaints Management workshops for all staff, including the management team, The workshop is an interactive learning opportunity for staff at all levels to recognise potential safeguarding concerns and how to report/escalate their concerns and how they will be investigated, notified and resolved.

• The PIC will review all incidents with Healthcare Manager (HCM) as part of routine

Home visits.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• The PIC and CNM will oversee residents' care plans and ensure that they accurately reflect the assessed care needs of the residents. The PIC will ensure that the care plan is developed only after a series of validated assessments have been completed; the plan of care will then be developed in consultation with the resident and/or nominated representative.
• The PIC will ensure that residents' assessments are completed accurately, reviewed and updated as required to ensure they reflect the current status of the resident; this information will be shared at daily staff handover and safety pause meetings.
• The PIC/CNM will ensure that daily monitoring of fluid and food charts is undertaken to ensure they are recorded accurately and completely. Any deficits identified will be acted upon immediately, evaluated and recorded to guide practice. The PIC will ensure that all staff accurately record food and nutritional intake electronically and these records will be monitored closely by the PIC and CNM, who will work with nursing staff to ensure that residents' hydration and nutritional needs are being effectively met. They will also ensure that nursing staff identify the need for further review by the GP and/or dietitian and to consider the need for dietary fortification and/or supplementation.
• The PIC will ensure that the records clearly and accurately display ongoing monitoring of food and fluid intake. The PIC will ensure that when reviewing these records, any potential clinical risks are identified, reported, escalated and managed appropriately.
• The PIC/CNM will complete a care plan/documentation audit monthly and develop a Quality Improvement Plan (QIP) as necessary, the results of which will be shared with nurses and used as an opportunity for learning.
• The PIC will ensure that clinical documentation is reviewed daily by Clinical Nurse Manager to ensure completeness and accuracy in addressing individual resident's specific care needs.
• The PIC will ensure when reviewing Incidents, that the incident form records all the information required within each domain. The PIC will ensure that each incident is reviewed, investigated, screened for any alleged safeguarding risks, and that recommendations and reflective learning is recorded when completing the incident review.
• Quality improvements noted from these reviews will be shared with the team daily as part of handover/safety pause meetings, weekly as part of the management meeting and monthly as part of the Quality and Safety meeting.
• The PIC will ensure learnings from incident investigations are reviewed, evaluated and shared with the team.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The PIC will ensure that there are always appropriate staffing levels available to ensure the safe and effective operation of the Home and to ensure that resident care needs are met.
• The PIC will complete a risk assessment and add it to the Home's Risk Register in relation to specific contingency planning for the management of staff shortages. This contingency plan will focus on the need to prioritise resident care at all times. The PIC will ensure that nurses are aware of the appropriate escalation procedures in relation to staff shortages so that the contingency plan can be implemented without delay.
• The PIC will continue to be supported by the HCM in the achievement of all required objectives and in ensuring that there are safe, high-quality systems of governance and management in place. Key Performance Indicators (KPIs), identified risks and operational issues in the home are recorded and reviewed on a monthly basis by this senior management team to ensure sustainability of progress, to identify areas in need of improvement and take corrective actions if required.
• The PIC, with support from the HCM, will hold weekly management meetings with the home's management team to review KPIs and to agree quality improvement actions.
• The PIC and CNM will be visible and accessible and will conduct monitoring rounds every day to provide oversight, to be available to meet staff, residents and families and to review resident care and clinical practice. They will supervise workflow and care practices to ensure that staff are facilitated to provide high quality, safe and effective care to all the residents.
• The PIC, supported by Human Resources, is continuing to actively recruit to vacant positions, and since the inspection Nurses and HCAs have been recruited and have commenced in post.
• The PIC will ensure the progress reports are reviewed daily to ensure that complaints or concerns that may have been recorded within the progress reports are recorded as complaints and managed in line with the centre's complaints procedure.
• The Quality and Compliance Coordinator (QCC) will review all complaints to ensure the oversight and monitoring of adverse incidents involving residents is effective, ensuring they were appropriately recorded, reported, investigated and notified to the Chief Inspector in a timely manner. Any deficits in staff knowledge or awareness will be escalated to the PIC and discussed as part of a Reflective Practice meeting.
• Complaints management training has been scheduled for the management team within the centre, and is available to all staff via the Learning & Development online Academy.
• Records of resident meetings will be reviewed and any issues or concerns will be recorded as complaints and investigated in accordance with the Complaints Procedure.
• The PIC and CNM, with the support of the HCM, will ensure that there is oversight of the residents' documentation, assessments and care planning. The PIC will ensure changes to residents' care needs are accurately recorded and are used to plan and guide

care for the residents.
• The PIC, with the support of the Facilities team, has a planned program of works to complete the flooring and to undertake repainting of residents' bedrooms. Since the inspection, the flooring work has commenced with a planned completion date of 30/06/2026.
• The HCM will have a weekly meeting with the PIC to review recruitment, staffing deployment and allocation, incidents, complaints and other KPIs. The HCM will provide advice and support and agree objectives for quality improvements with the PIC.
• The HCM will report findings, actions and learning monthly to the senior executive team as part of monthly Governance meetings.
• The QCC will visit the Home on a weekly basis to provide additional support to DON and to assist in induction of new staff.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC will ensure that all incidents and complaints are screened regularly and that all incidents that meet the criteria for notification to the Authority are submitted to the Chief Inspector within the required timeframe, in accordance with legislative requirements.
• The HCM will monitor compliance with this each week as part of regular management meetings with the PIC.
• The PIC and HCM will continue to review incidents monthly and will ensure that quality improvement plans are developed and implemented to address any learning outcomes identified.
• The Healthcare Manager, Quality and Safety will conduct Safeguarding and Complaints workshops for all staff including the management team. The workshop is an interactive learning opportunity for staff at all levels to recognise potential safeguarding concerns and how to report/escalate their concerns and an outline of how they will be investigated, notified and resolved.
• The QCC will continue to review progress notes for any potential Safeguarding concerns. A QIP will be developed as appropriate and will be implemented by the PIC. An after-action review meeting will be held with PIC, CNM and HCM to discuss progress and ensure the QIP is effective.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The PIC, supported by the HCM, will review incidents, communication records and progress reports weekly to ensure that any issues, concerns or expressions of dissatisfaction are recorded as complaints, addressed and responded to in line with the centre's Complaints Procedure. • Complaints management and awareness training has been scheduled for all staff in the centre, including the management team. • HSEland "Dealing with Complaints Effectively" is available for all staff on the Learning & Development online Academy. • Records of resident meetings will be reviewed, and any issues or concerns will be recorded as complaints and investigated in accordance with the Complaints Procedure. • The PIC will provide information about complaints received in the centre, including, source, learning outcomes and recommendations at the weekly management meetings. • The PIC will ensure learnings form complaints received will be recorded in a Quality improvement plan and shared among the team at daily handover and safety pause. • There is a monthly management team meeting in the home which reviews all operational aspects of the home, including key performance indicators, risk management, audits and progress on identified actions and updates on quality improvement initiatives. This meeting is well attended and includes at least one representative from each department. • The PIC will ensure that resident complaints are documented appropriately and escalated as necessary. The QCC will monitor daily progress notes to ensure all complaints are captured and recorded as such.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The PIC, HCM and Facilities team have undertaken a comprehensive review of the internal works, wall surfaces, painting works to be completed, a refurbishment plan is in place. • The flooring work has commenced with a phased plan in place for completion by 30/06/2026. This plan includes flooring work in the bedrooms and on the corridor leading to the external smoking shelter. • The Maintenance Person has replaced the torn wallpaper in the corridors and will include this as part of his monitoring checks. The PIC will monitor as part of daily walkabout so that repairs, when necessary, can be completed without delay. • The PIC and Facilities team will complete a review of the ventilation in the assisted resident bathroom on the Ground Floor, and a plan of works will be drawn up to improve ventilation. • The ventilation in the housekeeping room has been reviewed by the Facilities team, and an external extractor has been fitted to allow for better ventilation in this room.	

• The PIC and CNM will complete a review of the quantities of continence products being ordered and will ensure there is no excess, while maintaining a sufficient amount of continence wear on site to meet residents' needs.
• The PIC, CNM and IPC Lead Nurse Practitioner will review the storage of shower chairs and identify a more appropriate alternative location.
• The PIC will monitor storage as part of Manager's daily walkabout audit and any items found stored inappropriately will be removed.
• The PIC, with the support of the HCM, will ensure Facilities works are escalated and reviewed with the Facilities team, and progress on the works reported are reviewed at the Monthly Governance meeting.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• The PIC will ensure that residents' care plans are person centred and developed in consultation with the resident / representative.
• The care plan will focus on what matters to the resident and will incorporate the Age Friendly framework, the 4 m's (what matters to me, medication, mentation and mobility).
• The PIC/CNM will complete a care plan audit monthly and develop a QIP as necessary, the results of which will be shared with nurses and used as an opportunity for learning.
• For those residents with actual/potential skin integrity issues, the PIC will ensure that appropriate assessments are carried out and an individualized skin integrity care plan will be developed to ensure that the care interventions are appropriate.
• The PIC will ensure that any resident that presents with or develops a wound will have a wound assessment completed and an appropriate plan of care will be developed in line with best wound management practice guidelines. The individual wound care plan will be clearly outlined; progress updates will be documented and will be regularly updated.
• Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings. Any changes or developments in the resident's condition or plan of care will be updated as they occur.
• The PIC will develop a QIP as necessary, the results of which will be shared with nurses and used as an opportunity for learning.
• The PIC and CNM will review the assessments and care plans with the named nurses to ensure that assessments inform the plan of care, that the care plan is individualised and person-centred, considering the resident's current medical, health and lifestyle status.
• The PIC/CNM will ensure resident pain assessments are completed in line with the residents' pain management requirements. The PIC/CNM will review residents' pain management at daily handovers/safety pauses and ensure that the residents care plan is updated accordingly to reflect any changes.
• The PIC and nursing management team will provide support, guidance and direction to

nursing staff on clinical documentation, and will monitor the accuracy and quality of the clinical records. Where deficits are noted, they will work with the individual nurses to ensure that the overall quality of documentation improves.
• The PIC will complete a weekly review of clinical documentation to ensure that the care plan guides the delivery of care, and that the care delivered is reviewed and evaluated appropriately and in accordance with policy.
• Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings. Any changes or developments in the resident's condition or plan of care will be updated as they occur.
• The PIC and CNM will ensure all assessments for specialised equipment are completed and recommendations identified from the assessments are followed through to ensure residents receive optimum care.
• The PIC and CNM will ensure that the effectiveness of the specialised equipment is assessed, evaluated and reflected within the resident's care plan.
• The PIC will complete a review on wound management training for all nursing staff. The PIC will ensure that staff attend Skin Smart training and that a skin smart champion is assigned in the Home.
• The PIC/CNM will attend onsite reviews with the TVN to ensure any recommendations are implemented, documented in the care plan and communicated with the team during safety pause and handover.
• The PIC/CNM will ensure these recommendations are discussed weekly as part of the management meeting with the HCM.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC will ensure that all staff receive regular mandatory safeguarding training and refresher updates annually, including training in the National Standards for Adult Safeguarding.
• The HCM, Quality & Safety will chair an After-Action Review of recent significant incidents to highlight to the staff and the entire management team the importance of recognising, reporting, escalating, investigating and resolving all forms of abuse
• The PIC, supported by the Healthcare Manager will be aware of their responsibilities in recognising, reporting and responding to any allegations of abuse, including escalating any concerns appropriately.
• The PIC will ensure that any suspicion, concern, or allegation of abuse will be thoroughly investigated (including the notification of all such suspicions or allegations to the Authority) in accordance with the centre's Safeguarding policies.
• The PIC will ensure that all documentation relating to preliminary screening is fully completed and uploaded to the electronic record.
• The HCM will work with the PIC to ensure that recommendations and quality improvements are implemented.

• The HCM has scheduled a Safeguarding workshop for the management team to facilitate open discussion and provide clarity regarding their roles and responsibilities in the management of safeguarding risks and each individual staff member's responsibilities in the event of a safeguarding incident in terms of immediate actions, escalation, preliminary screening, and investigation.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient	Substantially Compliant	Yellow	30/06/2026

	resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	31/07/2026
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	31/07/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably	Not Compliant	Orange	31/05/2026

	practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/05/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/05/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/05/2026