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:	Bushfield Care Centre
Name of provider:	Genesis Healthcare Oranmore Ltd
Address of centre:	Bushfield, Oranmore, Galway
Type of inspection:	Unannounced
Date of inspection:	29 April 2026
Centre ID:	OSV-0005242
Fieldwork ID:	MON-0050406

About the designated centre

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

Bushfield Care Centre is a designated residential care centre for older people operated by Genesis Healthcare Oranmore Ltd. The centre is located in a peaceful rural setting in Bushfield, approximately 2 km from Oranmore Village, County Galway, with convenient access from the N6 motorway. The centre provides 24-hour nursing and personal care for up to 24 adult residents with a range of assessed dependency levels. The service accommodates both male and female residents over the age of 18 years requiring long-term residential care, respite care, convalescent care, dementia care, palliative and end-of-life care, and care for adults with physical disabilities.

Bushfield Care Centre is a purpose-designed, single-storey nursing home that promotes accessibility, independence and safety. Accommodation comprises a combination of single and twin bedrooms together with communal dining and sitting rooms, therapy facilities, secure landscaped gardens and outdoor spaces, and a quiet oratory for residents and visitors. Residents are encouraged to personalise their bedrooms and to maintain their independence and lifestyle choices within a homely environment.

The service is committed to providing person-centred care that respects the rights, dignity, privacy and individuality of every resident. Care is delivered by a multidisciplinary team of nursing, healthcare, catering, household, maintenance, administration and activities staff, with access to General Practitioner services and a range of allied health professionals.

Residents are supported to enjoy a meaningful and fulfilling quality of life through an extensive programme of social, recreational and therapeutic activities tailored to individual interests and abilities. The centre promotes resident choice, autonomy and community engagement, facilitates access to independent advocacy services and religious services, and actively encourages residents to participate in decisions about their care and the running of the centre through regular resident meetings and ongoing consultation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

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
Wednesday 29 April 2026	09:00hrs to 17:00hrs	Sean Ryan	Lead
Wednesday 29 April 2026	09:00hrs to 17:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in Bushfield Care Centre spoke positively about living in the centre and spoke favourably about changes in the management and service provision. Residents described a sense of stability within the centre and said they were familiar with the staff caring for them, which helped them to feel safe and comfortable in their home. Residents also complimented improvements in the quality and variety of activities available, the quality of food provided, and the overall atmosphere within the centre.

This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). Inspectors also reviewed unsolicited information received by the office of the Chief Inspector, and notifications received from the provider.

Inspectors arrived unannounced at the centre in the early morning and were met by night staff, who provided an overview of the residents living in the centre and the arrangements in place at that time. Inspectors completed a walk-through of the centre and found the environment to be visibly clean, calm, and relaxed. Staff were observed to be carrying out their duties in an organised and unhurried manner. At the time of the inspectors' arrival, no residents were up and about within the centre. Shortly afterwards, a small number of residents were observed in the dining room having breakfast. Staff informed inspectors that these residents had chosen to get up early, in line with their individual preferences and routines. Overall, the atmosphere within the centre during the morning was peaceful and respectful of residents' choices and comfort.

Inspectors observed periods during the early morning where residents who had chosen to get up early, were left waiting in the dining room unsupervised. This occurred at times when staff were also supporting other residents who required the assistance of two staff members to get up and begin their day.

During a walk-through of the centre, inspectors also observed a number of premises and fire safety risks. This included fire doors being held open using items of furniture, including the kitchen door. In addition, some doors were not closing effectively when released. These findings presented a potential risk to effective fire containment within the centre meaning that if a fire occurred it would spread throughout the centre.

Residents spoke about ongoing improvements to the premises and acknowledged that works were being completed within the centre. Inspectors observed that some refurbishment and maintenance works were in progress at the time of inspection, including external painting and works relating to heating and hot water systems. However, areas of the premises were observed to be in a poor state of repair,

including aspects of the flooring, bedroom furnishings, and general decorative upkeep.

Inspectors met with all residents and spoke with a number of residents in more detail regarding their experience of living in the centre. Residents consistently reported that they had always felt well-cared for and supported. Residents spoke positively about the local management team and said they had seen and met members of the team within the centre, although some residents felt they had not yet had sufficient opportunity for more meaningful engagement with them.

Residents described the atmosphere within the centre as pleasant and said that they experienced no significant restrictions to their day-to-day lives, choices, food quality, or routines. Residents also told inspectors that access to health care services, including general practitioner (GP) and physiotherapy services, were appropriate and consistent. However, some residents raised concerns regarding changes to additional service charges associated with certain health care services. While residents confirmed that written communication had been provided regarding these charges, some felt there had been limited consultation or engagement beyond this.

Residents were complimentary about the dining experience within the centre and spoke positively about the quality of the food provided, which was prepared and cooked in the centre. Residents told inspectors that they were offered choice at mealtimes, received adequate quantities of food, and could request additional portions if they wished. Residents also confirmed that snacks and drinks were readily available to them throughout the day. Residents described the menu as varied and said they enjoyed the range of options available. They also reported that they were encouraged to provide feedback on meals and menus, and that suggested changes made by residents had been implemented by the service.

Residents spoke positively about the activities programme and they said that there had been noticeable improvements in the range and frequency of activities available to them. Residents described having opportunities to participate in both group and individual activities in accordance with their interests and preferences and said they felt encouraged and supported by staff to take part in activities of their choosing.

Visitors who spoke with inspectors expressed high levels of satisfaction with the care and support provided to their relatives in the centre. While some visitors described an initial sense of anxiety when their relative first moved into residential care, particularly where they had no previous experience of nursing home care, they said the centre had become a "home from home" for their relatives. Visitors spoke positively about staff, describing them as caring and supportive, and said they were kept informed and involved in their relatives' care.

The next two sections of the report present the findings of this inspection in relation to capacity and capability of the provider, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

The findings of this inspection were that the provider had established a management structure that was responsible for the provision of safe and quality care to the residents. However, accountability and responsibility for key aspects of the service were not clearly defined within the management structure, and this impacted on the implementation of systems to ensure that the service provided to residents was safe and effectively monitored. In particular, while the provider was undertaking a significant programme of fire safety works in the centre, the management and oversight of these works, including their impact on existing fire safety precautions, evacuation procedures, and risks to residents, were not effectively managed.

Following the inspection, an urgent compliance plan request was issued to the provider due to the significant fire safety risks identified, which posed a risk to the safety and welfare of residents. However, the initial response received from the provider did not provide sufficient assurance regarding the management of these risks. Further clarification was sought, particularly in relation to the safe and timely evacuation of residents, and the information subsequently submitted provided the required assurances the the risks were being appropriately managed and addressed.

Inspectors also reviewed unsolicited information received by the office of the Chief Inspector. During the inspections, elements of the information were found to be partially substantiated.

Genesis Healthcare Oranmore Limited is the registered provider of this designated centre and was first registered by the Chief Inspector in February 2026. It is a company comprised of a board of three directors, who are involved in the operation of other designated centres for older persons. The registered provider was represented by one director in engagement with the Chief Inspector.

The organisational structure supporting the designated centre consisted of a board of directors, and an operations manager who was a person participating in the management of the centre. The operations manager was responsible for monitoring clinical and operational aspects of the service, in addition to providing oversight and governance support to the person in charge. Within the centre, a person in charge had been appointed and was working full-time in the centre. They were responsible for the direction and supervision of care provided to residents. The person in charge was supported clinically, and administratively, by an assistant director of nursing, and a clinical nurse manager. Responsibilities for key aspects of the service were delegated to members of the nurse management team to support the person in charge to maintain oversight of the quality and safety of the service provided to residents.

This centre was registered with known risks relating to the premises and fire safety. Within the provider's application to register the centre, the provider had given a

commitment to address these known risks. The centre was therefore registered subject to two additional restrictive conditions. Condition 4 required the provider to complete fire safety works, and Condition 5 required premises works to be carried out, in line with a phased project plan of works submitted by the provider to the Chief Inspector in December 2025. These conditions also restricted the admission or transfer of residents into the centre until the required works had been completed. This inspection found that while the provider had commenced works to address these risks, aspects of the required high-risk fire safety and premises works had not been completed in line with the project plan submitted to the Chief Inspector.

Inspectors found that lines of accountability and authority were not clearly defined within the organisational structure. For example, it was unclear who held responsibility for key aspects of the service such as the oversight and management of risk, safeguarding, and the management of complaints. The impact of this was inadequate and ineffective risk management systems, and systems to monitor and evaluate the quality of the service. In particular, inspectors found poor oversight and management of fire safety and premises-related risks which had the potential to impact on the safety and welfare of residents.

The system in place to manage risk was not effective. The centre's risk management policy detailed the interventions that should be in place for the oversight, assessment, and monitoring of risk in the centre. This included maintaining a risk register to record all potential risks to residents' safety and welfare. However, a review of the centre's risk management systems found that these arrangements were not implemented. While a risk register was in place, risk assessments had not been reviewed, updated, or further developed by the provider to ensure that known risks within the service were appropriately identified, assessed, monitored and managed. Consequently, there were no effective risk management systems in place to manage the potential risk to residents' safety and welfare.

The provider had systems in place to record and review incidents involving residents. However, inspectors found that incidents were not always comprehensively documented or appropriately investigated, and records reviewed did not consistently contain all information required to demonstrate effective review and follow-up on incidents. For example, an incident of unexplained bruising had not been fully reviewed in line with the centre's safeguarding procedures to determine all potential contributing factors and whether further actions were required. This significantly impacted on the registered provider’s ability to identify, respond to, and manage risk in the centre, and ensure a safe and quality care environment for residents.

The oversight and system of auditing was not effective. While there was a schedule of clinical and environmental audits available for review, the audits were not completed in line with this schedule. A sample of audits was completed each month included call bell response time, linen audits, environmental cleanliness and nutrition. The audits identified areas for improvement however, they did not include any analysis in relation to the contributing factors for areas of risk or requiring improvement, and therefore no quality improvement plan had been developed.

A review of staffing rosters found that staffing levels were adequate to meet the needs of the current 24 residents in the centre, and for the size and layout of the building. The team providing direct care to residents consisted of registered nurses, and a team of health care assistants. There were sufficient numbers of housekeeping, activities, catering and maintenance staff in place. However, inspectors found that the management and deployment of staff, including the allocation of duties and responsibilities during shifts, impacted staff availability to provide supervision and support to residents at all times.

A programme of training was in place for staff, which included areas such as fire safety, safeguarding and supporting residents living with dementia. However, a number of staff had not completed training or were not appropriately trained for the roles they were undertaking. This was identified with staff who had responsibility for the evacuation of residents from the centre in the event of a fire emergency. For example, staff did not demonstrate an appropriate level of knowledge in relation to fire safety and evacuation procedures. Inspectors observed poor practice whereby fire doors were held open with pieces of furniture, effectively compromising their function to contain the spread of smoke and fire.

There were arrangements in place to induct, orientate, support and supervise staff through senior management presence.

The provider maintained a complaints register to record complaints received regarding the quality and safety of the service. Records reviewed by inspectors showed that complaints made through formal processes were generally documented. However, the records did not consistently demonstrate that complaints had been fully investigated or that the outcomes of investigations had been clearly documented. In addition, inspectors were informed of additional complaints and concerns raised by residents which had not been recorded or managed through the centre's complaints process, and therefore had not been formally investigated or reviewed.

Regulation 14: Persons in charge

The person in charge was a registered nurse with the required experience in the care of older persons, and worked full-time in the centre. The person in charge had the overall clinical responsibility for the delivery of health and social care to the residents.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of the current residents, in line with the statement of purpose.

There were satisfactory levels of health care staff on duty to support nursing staff. The staffing compliment included laundry, catering, activities staff and administration staff. There was adequate levels of staff allocated to cleaning of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Some staff had not completed appropriate training to ensure the delivery of effective and safe care to residents. This was evidenced by;

- A number of staff had not completed fire safety training, including fire safety management and evacuation procedures. In addition, not all staff demonstrated an appropriate awareness of fire safety practices or the centre's evacuation procedures.
  Some staff had not completed, or had expired training in safeguarding of vulnerable people.
- Some staff had not completed, or had expired, training in medication management and manual handling in line with the providers training policy and procedures. In addition, some staff had not completed training in the delivery of emergency life-saving interventions, in line with some residents' care plans.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to progress and complete required fire safety works in line with the phased project plan of works submitted to the Chief Inspector. As a result, the provider had breached Condition 4 and 5 attached to the registration of this centre. Inspectors found poor oversight and management of ongoing fire and premises works, including inadequate monitoring of outstanding and completed works and ineffective management of the risks associated with incomplete fire safety and premises works within the centre.

While a management structure was in place, inspectors found that lines of accountability and responsibility for the oversight and monitoring of key aspects of the service were not clear. This included the oversight of risk management, incident

management system, and complaints management. Additionally, there were inconsistent and poorly defined systems in place to escalate risks to the provider.

The poorly defined organisational structure impacted on the management systems in place to ensure the service provided was safe and appropriately monitored. This was evidenced by;

- Ineffective risk management systems to monitor and manage known risks with the potential to impact safety and welfare of residents living in the centre.
- Poor oversight of incidents to ensure that the centre's safeguarding procedures were implemented. Consequently, a potential safeguarding incident was not appropriately documented and investigated.
- Poor oversight of the centre's complaints management system, and escalation of complaints, to ensure complaints were managed in line with the requirements of the regulations.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifiable events were appropriately notified to the Chief Inspector of Social Services, within the required time-frame.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints policy and procedure had not been updated to reflect changes in regulatory requirements for the management of complaints.

Inspectors received information consistent with complaints relating to the organisation and management of the staffing resources. While residents confirmed that these concerns had been raised with staff, and staff also confirmed that the residents had raised these issues, there was no documented evidence that the complaints had been recorded or managed in line with the requirements of the regulations.

In addition, records reviewed did not evidence that documented complaints were fully investigated in line with the requirements of the regulations.

Judgment: Not compliant

Quality and safety

Residents were satisfied with the quality of the service, and reported feeling safe and content living in the centre. There was a person-centred approach to care, and residents' well-being and independence were promoted. However, the findings of this inspection were that the provider did not ensure that residents received care in an environment that protected them from the risk of fire through appropriate fire management and containment measures. In addition, residents' rights were not fully upheld in all aspects of the service, particularly in relation to choice and consultation regarding services provided within the centre.

Inspectors reviewed fire safety arrangements and found that there was a significant lack of effective oversight and management of fire risks within the centre. The provider had not ensured that adequate fire precautions were in place, and appropriate risk assessment and control measures had not been implemented to protect residents from the risk of fire. Fire safety works had not been completed in accordance with the proposed time-lines and condition of registration. This included essential fire safety measures such as effective fire containment through appropriate compartmentation and provision of fully functioning fire doors. This was compounded by a lack of staff knowledge in relation to the fire risks present in the centre and the evacuation procedure to be followed in the event of a fire emergency. These findings posed a significant risk to the safety and welfare of residents living in the centre. As a result, an urgent compliance plan was requested from the provider in relation to fire safety concerns identified during the inspection. The response received provided assurance that the risks were being addressed and appropriately managed.

Premises works to address issues relating to the heating and hot water systems were ongoing at the time of inspection. In addition, external painting works to the building were in progress. However, inspectors observed that a number of areas within the premises were not maintained in a satisfactory state of repair and had not been addressed in line with the phased project plan of works submitted by the provider. This included areas in poor states of repair, such as damaged flooring, worn bedroom areas, damaged doors, and chipped or worn paint throughout parts of the premises.

A sample of residents individual assessment and care plans were reviewed. All residents had a care plan, and there was evidence that residents needs had been assessed using validated assessment tools. Care plans were reflective of residents actual care needs and updated following a change in their needs.

Residents were supported to access a general practitioner (GP) of their choice and had access to GP services as required. Arrangements were also in place for residents to be referred to other health care professionals for further assessment and treatment, including dietitians, speech and language therapists, and tissue viability

nursing expertise. Inspectors found that the recommendations from these professionals was generally implemented.

Arrangements were in place for the service to provide compassionate end-of-life care to residents in accordance with residents' preferences and wishes. Staff had access to specialist palliative care services for additional support and guidance to ensure residents end-of-life care needs could be met.

Residents' nutritional needs and risks were appropriately assessed and monitored. Where required, residents had access to specialist assessment by dietetic and speech and language services, which informed the development of person-centred nutritional care plans. These care plans were communicated to staff involved in the provision of care and in meal preparation. Systems were in place to monitor residents nutritional status, including regular weight monitoring and more frequent review, where indicated. Additional monitoring of residents' food and fluid intake was implemented, as required.

Residents reported that staff made them feel at home in the centre and that they were treated with dignity and respect. Residents were facilitated to access a varied and inclusive activity programme in the centre. Residents were engaged in activities on a daily basis and residents confirmed to the inspectors that they were satisfied with the activities programme.

Inspectors observed that residents were free to exercise choice in how to spend their day. However, inspectors found that residents were not always afforded choice with regard to the services they may choose, or not choose to avail of, and the charges for such services. While residents were consulted about their care needs and the overall quality of the service, through scheduled resident forum meetings, residents reported that they were not fully consulted regarding fees and charges associated with living in the centre.

Visiting was found to be unrestricted, and residents could receiving receive visitors in either their private accommodation or designated area if they wished.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 13: End of life

Residents and, where appropriate, their relatives, were involved in the decision making process with regard to end of life wishes and advanced care plans in consultation with the resident's General Practitioner (GP).

Judgment: Compliant

Regulation 17: Premises

The registered provider had not ensured that the premises were maintained in a manner consistent with the requirements of Regulation 17 and the conditions attached to the centre's registration. Inspectors found deficits in the oversight and progression of premises works identified within the phased project plan submitted to the Chief Inspector. This included:

- Planned repair and replacement works to flooring throughout bedrooms, corridors, and communal areas had not been completed.
- Bedroom refurbishment works had not been completed and included outstanding painting works, furniture replacement and repairs, and improvements intended to enhance the physical environment for residents.

In addition, the management of storage areas within the centre was poor. Inspectors observed residents equipment being stored in vacant bedrooms and inappropriate storage of equipment within electrical distribution rooms.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were provided with wholesome and nutritious food choices for their meals and snacks, and refreshments were made available at the residents' request. Menus were developed in consideration with residents' individual likes, preferences and, where necessary, their specific dietary or therapeutic diet requirements, as detailed in residents care plans.

Daily menus were displayed in suitable formats, and in appropriate locations, so that residents knew what was available at meal-times. There was adequate numbers of staff available to assist residents with their meals.

There were adequate arrangements in place to monitor residents at risk of malnutrition or dehydration. This included weekly weights, maintaining a food intake monitoring chart, and timely referral to dietetic and speech and language services. Inspectors observed that residents received food that was appropriate to assessed needs.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had failed to ensure compliance with regulatory requirements relating to fire precautions and had not ensured that residents were protected from the risk of fire. There was a significant lack of effective monitoring, management oversight, and governance arrangements in relation to fire safety practices and the management of identified fire risks within the service. As a result, an urgent compliance plan was requested from the provider in relation to fire safety concerns identified during the inspection. The response received provided assurance that the risks were being addressed and appropriately managed.

The following findings identified during the inspection demonstrated significant deficits in the fire safety arrangements within the centre:

- Fire safety drills were not being carried out in a manner that reflected the fire risks identified within the centre or the evacuation strategy required to support the safe and timely evacuation of all residents in the event of a fire emergency. This was compounded by a lack of staff awareness and training that reflected fire risks within the centre.
- Flammable items such as cardboard boxes, pieces of furniture and electrical equipment were stored in an electrical plant room. This presented a potential fire risk, and an immediate action was issued on the day of the inspection requiring removal of these items.
- Required improvements relating to fire containment and compartmentation measures throughout the centre had not been fully progressed or completed. For example, deficits in relation to fire doors and the effectiveness of fire containment measures remained evident in the centre.
- Fire detection, alarm, and emergency lighting systems had not been fully upgraded or brought into line with the centre's fire safety improvement works.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre, as required or requested.

Services, such as physiotherapy, were available to residents weekly, and services such as tissue viability nursing expertise, speech and language and dietetics were available through a system of referral.

There was evidence that recommendations made by health care professionals were followed up and monitored. This supported the delivery of care, in line with residents' assessed needs.

Judgment: Compliant

Regulation 9: Residents' rights

Residents told inspectors that their choice was not always respected in the context of the services they availed of in the centre.

Residents reported that they were not adequately consulted regarding the organisation of the service. While residents had received written correspondence informing them of increased service charges, they stated that there was limited further consultation or engagement in relation to these charges.

Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bushfield Care Centre OSV-0005242

Inspection ID: MON-0050406

Date of inspection: 29/04/2026

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Registered Provider acknowledges the findings of the inspection and has completed a comprehensive review of the Centre's training matrix to identify all staff with outstanding or expired mandatory training. An immediate action plan was implemented to address identified deficits in fire safety, safeguarding, medication management, manual handling and emergency life support training. Most training sessions have been completed and the remaining have been scheduled with staff requiring refresher training have been prioritised. Specific actions: • Completion of fire safety training for all staff, including evacuation procedures, compartmentation awareness, building layout, escape routes and emergency response procedures. • In light of the on-going building works in the building staff conduct fire drills twice a week to ensure staff are knowledgeable about the fire evacuation plan as it changes. Staff receive daily updates on the building works to ensure they remain aware of progress and changes to the building. • The safeguarding training for all staff with expired or outstanding certification has been completed. • All nursing staff who required refresher training have completed medication management training. • Completion of manual handling refresher training in accordance with the provider's training policy, with the exception of one staff member who is on maternity leave. • Review of emergency life support training requirements to ensure staff possess the knowledge and skills necessary to respond appropriately to residents' assessed needs. CPR Training has been scheduled for July 14th 15th 22nd and 30th. • Management has introduced monthly monitoring of training compliance through governance meetings. • Management has implemented a training compliance tracker to identify training due dates in advance and ensure refresher training is completed prior to expiry.	

• Introduction of competency assessments, particularly in relation to fire safety and evacuation procedures, to provide assurance that staff can safely apply their training in practice.
The Person in Charge will maintain oversight of training compliance and report training completion rates through the centre's governance and quality assurance systems. The Registered Provider will ensure that all staff have access to appropriate training relevant to their role and responsibilities.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23: Governance and management
Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider acknowledges the findings of the inspection and has undertaken a comprehensive review of the governance and management arrangements within the designated centre to ensure there is a clearly defined management structure and effective management systems in place to support the delivery of safe, high-quality care and services to residents.
The organisational governance structure has been strengthened and clearly defines the lines of authority, accountability and responsibility from the Registered Provider and Head of Operations through to the Person in Charge and wider management team. The roles and responsibilities of the Person in Charge, Assistant Director of Nursing, Clinical Nurse Manager and department leads have been reviewed and clarified to ensure effective oversight of all aspects of service delivery, including risk management, fire safety, safeguarding, incident management, complaints management, regulatory compliance, audit activity and quality improvement.
The recent appointment of a Clinical Governance, Risk and Compliance Lead forms part of the organisation's enhanced governance and assurance framework, which is been implemented across all designated centres within the group. This will provide structured oversight of quality, safety, regulatory compliance, risk management and key performance indicators, ensuring consistent monitoring, escalation and assurance processes at local and organisational level. Part of this project is the development of a group wide KPI dashboard which will allow oversight of all aspects of the service and ensure avenues for escalation of all elements that require review. Accordingly, this action represents an embedded component of the organisation's strategic governance model and continuous quality improvement programme, demonstrating a proactive and sustainable approach to regulatory compliance rather than a centre specific response to inspection findings.

Formal governance and quality meetings have been implemented and are held on a weekly basis within the centre. These meetings include review of incidents, complaints, safeguarding concerns, clinical risks, staffing, training compliance, audit outcomes, regulatory requirements and progress against quality improvement actions. Detailed records and action trackers are maintained, with clear accountability assigned for the completion of identified actions. Monthly governance oversight meetings are also held between the Person in Charge and Head of Operations to review service performance, emerging risks and regulatory compliance.

The centre's risk management systems have been comprehensively reviewed and strengthened. The risk register has been redeveloped to ensure that all identified risks are appropriately assessed, documented, monitored and reviewed. Risk assessments have been updated to reflect known risks within the service, including those relating to fire safety, evacuation procedures, compartmentation works, building refurbishment works and resident safety. Clear escalation processes have been established to ensure that significant risks are communicated promptly to senior management and the Registered Provider for review and action.

The provider has also strengthened systems for monitoring incidents, complaints and safeguarding concerns to ensure all matters are appropriately documented, investigated, reviewed and closed in accordance with regulatory requirements and organisational policy. Audit processes have been enhanced to ensure that identified deficits are analysed, trends are identified, corrective actions are implemented and quality improvement plans are developed and monitored through to completion.

In response to the inspection findings relating to fire safety and premises works, enhanced oversight arrangements have been implemented to monitor the completion of the fire safety and refurbishment programme. The Head of Operations maintains direct oversight of the project in conjunction with the Person in Charge, maintenance personnel and external contractors. Progress against the project plan is reviewed regularly and discussed through governance meetings to ensure timely completion of outstanding works and effective management of any associated risks.

The Registered Provider has maintained ongoing engagement and communication with HIQA regarding the fire safety improvement programme and compliance with Conditions 4 and 5 of registration. Regular updates have been provided to HIQA regarding completed and outstanding works, associated risk assessments, fire drill outcomes, evacuation arrangements and interim control measures. Additional assurances have also been provided in relation to resident safety and the management of fire risks while works remain ongoing. The provider remains committed to completing all outstanding works within the agreed timeframe and to maintaining open communication with HIQA regarding progress.

These measures provide assurance that robust governance, management, quality assurance and risk management systems are now in place to ensure the service is safe, effectively monitored and continuously improving in accordance with regulatory requirements and the needs of residents.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints policy has been reviewed and updated to reflect current legislative requirements.
Actions completed include:
• Appointment of designated complaints personnel in accordance with regulatory requirements.
• Introduction of a revised complaints register.
• Senior management team members have completed complaints handling training on-line and formal in-person complaints handling training is being scheduled for relevant personnel across the group.
• Review of all recent complaints to ensure appropriate investigation and closure.
• Monthly review of complaints through governance meetings.
• There is a discussion of complaints regularly at the daily handover/huddle so that all staff are aware of their responsibilities in the reporting and management of complaints.
All complaints, concerns and feedback raised by residents or representatives will be formally documented, investigated and responded to in accordance with Regulation 34.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider remains committed to completion of the phased premises improvement programme submitted to the Chief Inspector as part of the registration process.
Works completed to date include:
• Replacement of the boiler and improvements to heating and hot water systems.
• External painting works.
• Ongoing refurbishment of resident accommodation and communal areas.
Outstanding works have been incorporated into a revised project schedule and include:
• Replacement and repair of flooring in identified areas.
• Refurbishment of bedrooms, including furniture replacement and decorative improvements.
• Repair and repainting of doors and damaged surfaces.
• Review and reorganisation of storage arrangements throughout the centre.
• Removal of inappropriate storage from electrical service rooms.
• Appropriate allocation of equipment storage areas.
Progress of all premises works is monitored weekly

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider acknowledges the findings of the inspection and remains fully committed to completing the fire safety improvement programme and ensuring the safety and welfare of all residents living in the centre.
Following the inspection, immediate actions were taken to address identified fire safety concerns and strengthen the management of fire risks within the centre. All fire doors throughout the centre were reviewed, inappropriate practices affecting fire containment were addressed, and staff were reminded of their responsibilities regarding fire safety, compartmentation and evacuation procedures. A review of all fire safety risk assessments was completed and additional control measures were implemented where required.
The Registered Provider has maintained ongoing engagement and communication with HIQA regarding the fire safety improvement programme and compliance with Conditions 4 and 5 of registration. Detailed updates have been provided regarding the phased programme of fire safety works, associated risk assessments, fire drill outcomes, evacuation procedures and interim risk control measures implemented to protect residents while works remain ongoing.
A comprehensive fire risk assessment relating to the incomplete compartmentation works was completed and submitted to HIQA. Additional assurances were subsequently provided regarding the safe evacuation of residents and the management of fire risks within the centre. Multiple fire drills have been completed to test evacuation procedures, staffing arrangements and resident evacuation times, with learning outcomes reviewed and incorporated into ongoing fire safety management arrangements.
The provider has continued to progress the fire safety improvement programme in line with the revised schedule of works. All compartmentation works have now been completed at both ground floor and attic level. The building has been successfully divided into separate fire compartments and refurbishment works are progressing on a phased basis to ensure the safety of residents while the remaining works are completed. The phased approach allows areas of the building to be isolated from occupied areas and reduces the overall fire risk within the centre.
The fire alarm system and emergency lighting systems have been serviced, tested and certified by competent external contractors. Ongoing preventative maintenance and servicing arrangements remain in place to ensure compliance with relevant fire safety standards. Fire safety equipment, emergency lighting, fire alarm systems and means of escape continue to be monitored through routine inspections and maintenance programmes.
Fire safety governance arrangements have also been strengthened. Fire safety is now a standing agenda item at governance meetings and progress against the fire safety improvement programme is reviewed regularly by the Person in Charge, Head of Operations and Registered Provider. Fire risk assessments are reviewed on an ongoing basis and updated as works progress or where new risks are identified.
A review of staff training records was completed following the inspection and all staff requiring refresher training were identified. Fire safety training, including evacuation procedures, compartmentation awareness, building layout, escape routes, emergency response procedures and use of firefighting equipment, has been completed or scheduled for all relevant staff. In addition, regular fire drills and competency assessments are undertaken to provide assurance that staff can safely respond in the

event of a fire emergency and effectively evacuate residents from the centre.
The Registered Provider remains committed to the completion of all outstanding fire safety and refurbishment works within the agreed timeframe and will continue to provide updates to HIQA regarding progress. These measures provide assurance that adequate precautions are in place against the risk of fire, that fire precautions are subject to ongoing review, and that staff have received appropriate fire safety training to protect residents living in the centre.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The provider recognises the importance of meaningful consultation with residents regarding services and charges.
Actions include:
• Resident meetings to discuss service provision and proposed changes.
• Enhanced communication (letters and emails to both residents and nominated representatives where applicable) regarding optional services and associated charges.
• Opportunities for residents and representatives to provide feedback prior to implementation of changes. Family members have been invited to attend resident's meetings (with resident consent) and join subcommittees within the centre whereby they will also attend these meetings. An annual resident satisfaction survey will be issued following completion of all renovation works whereby feedback can be submitted anonymously if preferred.
• Recording of consultation outcomes and actions arising.
• Staff communicate daily with the residents regarding the ongoing building works.
The provider will continue to promote resident choice, consultation and participation in the organisation of the service.

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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/07/2026
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	14/08/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	21/07/2026

Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	21/07/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	07/05/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	07/05/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points,	Not Compliant	Red	07/05/2026

	first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	07/05/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	07/05/2026
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Red	07/05/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on	Not Compliant	Orange	30/07/2026

	foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	21/07/2026
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	21/07/2026