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:	Ballinamore Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Tully, Ballinamore, Leitrim
Type of inspection:	Unannounced
Date of inspection:	29 June 2026
Centre ID:	OSV-0005290
Fieldwork ID:	MON-0046638

About the designated centre

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

Ballinamore Community Nursing unit is a purpose-built facility that provides accommodation for 20 residents who require long-term residential care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. In the statement of purpose, the provider states that care is focused on a person centred approach where each resident is treated with dignity and respect. This centre is a modern building and is located in the town of Ballinamore. It is a short walk from the shops, library, church and business premises. Bedroom accommodation consists of 18 single bedrooms, and one twin occupancy bed room. All bedrooms have fully accessible en-suite facilities. A variety of communal accommodation is available and includes a sitting room, a dining area, a prayer room and visitors' room. The centre has a safe well cultivated garden area that has features such as bird feeders, flowers and shrubs to make it interesting for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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 29 June 2026	09:15hrs to 17:00hrs	Catherine Connolly-Gargan	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out to monitor the provider's compliance with the regulations, following receipt of unsolicited information received by the office of the Chief Inspector of Social services with concerns regarding the governance and management, and quality and safety of the service. The inspector's findings are discussed under the relevant regulations in this report.

Ballinamore Nursing Unit is a purpose-built nursing home. Residents' communal and bedroom accommodation is arranged on ground floor level. The designated centre is registered to accommodate 20 residents. There were 17 residents living in the centre at the time of this inspection. Necessary fire safety upgrading works were in progress, and on the day, works were taking place in a vacant single-occupancy bedroom and were organised to minimise any impact on the residents living in the centre. The inspector was told by the person in charge that a twin-occupancy bedroom 15 was closed to admissions by the provider pending completion of planned refurbishment works to address deficits in the layout of this bedroom to meet residents' needs.

On arrival, the inspector was met by the person in charge, and following brief introductions, the inspector completed a walk around the centre. This gave the inspector an opportunity to meet with residents and staff, to observe practices and to get an insight into the residents' experiences of living in the centre. The inspector observed that staff were assisting residents with getting up and going to the communal sitting room. A number of residents chose to sleep on later into the morning, and their wishes were respected by staff.

Residents told the inspector that they were satisfied with the service they received, the quality of their lives, and that their rights were respected in the centre. Residents said that they knew the staff well, and staff were kind to them. One resident said that staff 'are the best', and 'are always so ready and willing to help me'. A second resident told the inspector that they were 'very comfortable', felt safe, and they 'liked living' in the centre, and another told the inspector that 'there was no place on earth like this place'. Staff interactions with the residents were observed by the inspector to be respectful, caring and patient. Staff chatted with the residents as they carried out care tasks for them, and the residents were observed to be comfortable in the company of the staff and to respond positively to staff interactions with them.

The inspector observed that staff carried out appropriate hand hygiene, and there were sufficient hand gel stations and hand-washing sinks in all areas where resident care was provided. Clinical hand-washing sinks were available in each resident's bedroom for staff use close to the point of care delivery.

While the residents' lived environment was generally maintained to a satisfactory standard, the inspector observed that the floor surfaces on the corridors and the oratory were visibly unclean. These surfaces remained unclean following floor cleaning procedures taking place. The cleaning cart in use for transporting cleaning equipment during cleaning procedures in the centre, and another cleaning cart that the inspector was told was ready for use, were visibly unclean. The inspector also observed that large amounts of used linen were stored in a corridor, awaiting collection by an external laundering provider.

The residents' environment was accessible, and supported them to move around the centre safely and as they wished. The communal rooms were furnished with comfortable seating and tables for use by the residents, as they wished. With the exception of the twin-occupancy bedroom, all other residents' bedrooms were spacious and well laid out to meet the residents' needs. Many of the residents had been supported to personalise their bedrooms with photographs of their families and other personal items. The communal areas were homely, and were decorated with various ornaments and other memorabilia that were familiar to the residents.

Residents' social activities were facilitated in the sitting and dining rooms, both of which had tables available to support residents to participate in table-top activities. The social activity schedule for the day was displayed for the residents' information, and referenced varied planned activities to suit residents' interests, and the residents who spent time in the communal rooms were satisfied with, and participated in the social activities taking place. However, a number of other residents preferred to spend time in their bedrooms, and although the activity coordinator made efforts to visit these residents on the day to support them to participate in social activities, the records available of the social activities they preferred and had the opportunity to participate in were limited. The inspector also observed that staff did not consistently remain with residents in the communal rooms, and as a result, staff were not available during these times to respond to residents who were at risk of falling.

Residents told the inspector that they were listened to, they felt comfortable speaking to the staff regarding any dissatisfaction they had with the service they received, and that their concerns were addressed to their satisfaction. Residents also said that they felt safe in the centre, and that staff were always kind, and supported them to make choices about their day-to-day lives, and preferred routines.

The next two sections of the report, capacity and capability and quality and safety, will describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013 (as amended). The areas identified as requiring improvement are discussed in this report under the relevant regulations.

Capacity and capability

This unannounced inspection was completed to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), further to solicited and unsolicited information received by the office of the Chief Inspector, and to assess the provider's compliance with the regulations. This inspection found that while the centre's management and staff made efforts to ensure that residents' clinical and social care needs were met, inadequate oversight of the quality and safety of the service by the provider did not ensure that the service provided to residents was safe, appropriate and effectively monitored.

The registered provider of Ballinamore Nursing Unit is the Health Service Executive (HSE). The person in charge changed in March 2026, and the new person in charge was supported in their role by a clinical nurse manager (CNM), staff nurses, healthcare assistants, cleaning, catering, and administration staff. Maintenance of the premises was the responsibility of a centralised maintenance department, and a system was in place for communication of repair needs.

The findings of this inspection evidenced continued failure by the provider to maintain adequate oversight of the service, and as a consequence of this, significant risks to residents' safety from infection, delays in their access to healthcare and deficits in assessments of their care needs. These findings necessitated urgent action by the provider and submission of a compliance plan to assure the chief inspector regarding the centre's compliance with the regulations. While the provider's compliance plan response detailed a number of urgent actions taken, the response did not give adequate assurances regarding compliance with the regulations.

The provider's staffing model was dependent on the availability of agency staff to replace two staff nurses, two healthcare assistants and one cleaning staff member's current vacancies. There was not enough staff available to ensure that a staff member was available at all times in the communal rooms to respond to residents' needs. This staffing model did not ensure continuity of residents' care and service, and was not in line with the designated centre's statement of purpose. This is a repeated finding from a previous inspection and is discussed further under Regulation 23: Governance and management.

There was a system in place to monitor staff training; however, this inspection found that deficits in the standards of environmental cleaning and residents' assessment documentation did not give adequate assurances that staff were appropriately supervised in their roles. This is further discussed under Regulation 16: Training and staff development.

Arrangements for recording accidents and incidents involving residents in the centre were in place and were notified to the Health Information and Quality Authority as required by the regulations.

Regulation 14: Persons in charge

The person in charge commenced in their role in March 2026, and their management experience and qualifications meet the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

There were insufficient numbers of staff available to ensure that there was a staff member available at all times to respond to residents' needs for assistance and support in the two communal rooms. The inspector observed that residents who had an assessed risk of falling, and residents who needed staff support with their hydration needs, were alone in the communal rooms for varying periods of time during the day, while all the staff available were involved with assisting and providing care to other residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider did not ensure that staff were appropriately supervised according to their roles to ensure that they carried out their work to the required standards. This was evidenced by the following findings;

- Staff were not adhering to required infection prevention and control standards in the areas of cleaning of the floor surfaces, cleaner's carts, and residents' equipment. This significantly increased the risk of cross-infection to residents.
- Staff were not completing residents' care needs assessments accurately, and this posed a risk that residents' needs were not adequately assessed to ensure their needs were effectively met. For example, a number of residents' dependency level assessments and nutrition assessments reviewed by the inspector were not completed in line with the guidance available, and therefore could not be used to reliably inform the supports and care these residents needed.

Under this regulation, the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response **did not** provide assurances that the risk was effectively addressed.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure that staffing resources in the centre were effectively planned and managed in accordance with the designated centre's statement of purpose. The provider had a staffing model in place where staff vacancies and planned leave were replaced with agency staff. For example, agency staff were working in the centre for 228.75 hours in the week prior to the inspection. This staffing model was not sustainable, did not ensure continuity of residents' care, and was not in line with the designated centre's statement of purpose. This is a repeated finding from a previous inspection.

The registered provider did not have effective governance and oversight arrangements in place to ensure that the service provided to residents was safe, appropriate, consistent, and effectively monitored. This was evidenced by the following findings;

- Quality and safety monitoring systems in place were not identifying the deficiencies found in residents' assessments or in the cleaning and maintenance of the residents' environment and equipment.
- Management systems in place did not provide effective oversight of staff practices or ensure that residents' care needs were assessed to the required standard. In addition, monitoring processes failed to consistently identify and address deficiencies in residents' care assessments, access to healthcare services, and overall service delivery.
- The registered provider had also not ensured adequate oversight of residents' timely access to medical and healthcare services, or that their healthcare and nursing needs were met to an appropriate standard.

Under this regulation, the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response **did not** provide adequate assurances that the risk was effectively addressed.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications and quarterly reports were submitted as required and within the time frames, as specified by the regulations. A record of accidents and incidents involving residents in the centre was maintained. Systems were in place to ensure all incidents and accidents involving residents were notified as required.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the management and staff in the centre were committed to meeting residents' needs, and they were kind and caring to residents and respected their rights. However, this inspection found that significant actions were necessary to ensure residents had adequate access to their general practitioner (GP) and speech and language therapy specialists to meet their needs. Actions were also necessary to ensure residents' assessment documentation was completed as required. These deficits were impacting on a number of residents' wellbeing.

Although residents' care plans mostly informed their needs and ensured their needs were met to a satisfactory standard, not all assessments of their needs were completed as required, and this posed a significant risk that residents' care needs would not be effectively met.

Effective arrangements were not in place to ensure that necessary general practitioner (GP) and speech and language therapy consultations were timely. This was resulting in delays in residents receiving recommended pain medication, and accessing to speech and language therapists. This finding did not ensure residents' needs were met, and posed risks to their wellbeing.

Although the provider ensured that residents who attended the sitting room during the day had sufficient opportunities to participate in meaningful social activities that interested them and met their individual capabilities, assurances were not available that residents who wished to spend time in their bedrooms or did not wish to participate in the social activities facilitated in the sitting room had equal access to social activities in line with their preferences.

The layout and design of the twin-occupancy bedroom impacted on the personal and circulation space available to each resident. As a result, the chief inspector of social services attached a condition to the designated centre's registration, setting out criteria for accommodation of residents in this bedroom. At the time of this inspection, the provider had closed this bedroom to admissions, pending completion of a refurbishment plan to address the deficits identified.

While the provider had measures in place to protect residents from the risk of infection, failure to ensure that the floor surfaces and residents' equipment were adequately cleaned, and used laundry was appropriately segregated, posed a significant risk to residents' safety from infection. On the day of this inspection, the provider was required to take urgent action to address the inspector's findings. The is discussed further under Regulation 27: Infection control.

The provider had measures in place to protect residents from the risk of abuse. Each member of staff was facilitated to attend safeguarding training, and residents assured the inspector that they felt safe living in the centre.

Regulation 17: Premises

The layout of bedroom 15, a twin-occupancy bedroom, did not ensure the personal space available for each resident met their needs. A restrictive condition had been placed on the registration to review this room once the current occupants no longer resided in this bedroom. The room was vacant on this inspection.

Designated storage facilities for storage of residents' assistive equipment were reduced as the storeroom in the designated centre was also being used by the community occupational therapy service for storage of their equipment. Due to the limited space available in the designated storage room, a hoist was stored in the residents' communal shower/toilet. This inappropriate storage reduced the circulation space available in the communal shower/toilet for residents and posed a risk of injury to them.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider did not ensure that practices and procedures, consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority, are implemented by staff. On the day of the inspection, the inspector observed the following;

- Cleaning staff were not completing floor cleaning throughout the centre to satisfactory and necessary standards. The floor surfaces were visibly soiled, and were observed to remain unclean, and stained following completion of floor cleaning procedures in a number of areas.
- Environmental and surface cleaning equipment was not clean. For example, containers used for storage of cleaning cloths on the cleaning carts were visibly soiled. Dust, grit, smearing, and staining were observed in the base of these storage containers. Loose chocolate sweets were spilt among the cleaning cloths in a storage container on one cleaner's cart, and used tissues were observed in a storage containers on both cleaning carts. In addition, there was grit and dust visible on the surface of a tray on the base of both cleaning carts, and solidified matter was visible in the corners of these trays. This posed a significant risk of cross-infection to residents.

- There was a large amount of used linen stored awaiting collection for laundering by an external laundering contractor in a corridor area of the centre that was accessible to residents.
- Effective procedures were not in place to ensure that residents' equipment was cleaned following use. Although a system was in place, this was not being effectively implemented.

Under this regulation, the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response **did not** provide adequate assurances that the risk was effectively addressed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

This inspection found that actions were necessary in residents' care documentation to ensure that their care needs were adequately assessed and that their care plan information reliably guided staff on their current care needs and care delivery. This was evidenced by the following findings:

- The assessments of residents' nutrition and dependency needs were adequately completed. For example, as the nutrition and dependency needs assessment tools were not accurately completed for a number of residents, the information gleaned from these assessments could not be relied on to inform these residents' needs. This posed a risk that residents' needs would not be effectively identified and met.
- Residents' dependency (Barthel) and malnutrition universal screening (MUST) tools were not being completed as required and in accordance with evidence-based practice to inform residents' needs. Therefore, this information could not be relied on to inform residents' dependency levels and nutrition needs.
- Samples of residents' care plans reviewed to address the nutritional needs of residents were not sufficiently updated after reviews by health professionals. For example, some residents' care plans did not fully reference the most recent treatment plan recommended by the speech and language and dietician specialists. This posed a risk that pertinent information regarding these residents' care needs would not be effectively communicated to all staff.
- There was insufficient information available in a care plan developed for a resident experiencing pain to guide staff on effective monitoring of this resident's pain, and regarding the actions they should take to ensure that this resident's needs were met.

Judgment: Not compliant

Regulation 6: Health care

The provider did not ensure residents had timely access to appropriate medical and healthcare services to meet their needs, and that residents received a high standard of evidence-based nursing care to meet their needs. This was evidenced by the following findings;

- The provider had not ensured residents have timely access to medical care to meet their pain management needs. For example, a recommended change to a resident's pain medication made further to an assessment by palliative care services on 23 June 2026 had not been completed, and the resident continued to experience pain at the time of this inspection.
- The provider had not ensured that residents have timely access to speech and language therapy services to meet their needs. The inspector found that two residents experiencing difficulty with swallowing were waiting for assessment of their needs by a speech and language therapist since 16 April 2026 and 05 May 2026 respectively.

Under this regulation, the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response **did not** provide adequate assurances that the risk was effectively addressed.

Judgment: Not compliant

Regulation 8: Protection

Policies and procedures were in place and available to staff to guide them on safeguarding residents from abuse. The provider ensured that all staff were facilitated to attend safeguarding training, including agency staff. Staff were aware of the reporting procedures and of their responsibility to report any concerns they may have regarding residents' safety in the centre. Residents told the inspector that they felt safe in the centre.

All safeguarding incidents were recognised and appropriately investigated, reported and managed since the last inspection. Appropriate measures and arrangements were put in place to safeguard any residents involved in peer-to-peer incidents, including the development of effective safeguarding plans to ensure risks to any individual resident's safety were identified, managed and effectively mitigated.

Judgment: Compliant

Regulation 9: Residents' rights

Not all residents attended the scheduled social activities taking place in the sitting room, a number of residents stayed in their bedrooms, and although staff made efforts to regularly visit these residents to support them with opportunities to participate in suitable and their preferred social activities, records of the social activities these residents participated in were limited and therefore did not give adequate assurances that these residents' social care delivery was in accordance with their care plan information, and individual preferences.

Judgment: Substantially compliant

Regulation 11: Visits

Residents' families and friends were facilitated to visit them in the centre, and practical precautions were in place to manage any associated risks. Residents' access to their visitors was not restricted, and suitable facilities were available to ensure residents could meet their visitors in private outside of their bedrooms if they wished.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 11: Visits	Compliant

Compliance Plan for Ballinamore Nursing Unit OSV-0005290

Inspection ID: MON-0046638

Date of inspection: 29/06/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The person in charge and person participating in management conducted a review of staffing levels and resident dependency levels on 30/06/2026. This provided assurances that staffing resources are aligned to resident dependency and occupancy levels. • The person in charge completes a daily staffing allocation to ensure skill mix and allocation of tasks across the designated centre. • The person in charge and person participating in management reviewed the daily staff allocation to ensure designated staff supervision is available within communal areas during peak activity periods and where residents assessed as being at risk of falls require increased observation. There is one clinical staff member assigned to the supervision of residents in communal rooms during occupancy. • The person in charge and person participating in management are liaising with HR regarding the recruitment campaigns and process to replace existing vacancies within the centre. All vacant positions have been approved by local management and subject to the HR recruitment process. All vacant positions are backfilled with agency hours in the interim. It is envisioned recruitment into vacant positions will be completed by the 31/10/2026. • The person in charge is utilising predominantly HSE framework approved agency providers to ensure all staff provided are compliant with the required training standards. This is applicable for all staff grades required by the centre. The person in charge has requested a clearance pass from all agency providers to ensure staff have the appropriate training and skilled to conduct their required role. • The Person in Charge and person participating in management conduct regular reviews of staffing and workforce arrangements, including monitoring vacancies, leave, training compliance, and the use of agency staff. These reviews are reported to senior management as part of the centre's governance and management systems. • The person in charge monitors the centre's agency usage daily and reports weekly to the person participating in management to ensure it is consistent with the centre's staffing requirements and maintaining continuity of care using a consistent panel of agency staff. • The person in charge reviews the centre's staffing level and skill mix and rosters daily.	

Regulation 16: Training and staff development	Not Compliant

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

• The person in charge and person participating in management have completed a review of the staff supervision procedure within the designated centre on 30/06/2026.

• The person in charge and person participating in management have received support from the IPC team in refining the domestic staff supervision, adhering to required infection prevention and control standards in the areas of cleaning of the floor surfaces, cleaning carts, and residents' equipment. The 'I am clean' practice is reinforced within the designated centre by the person in charge and person participating in management to reduce the risk of cross-infection to residents.

• The IPC link nurses within the designated centre have received the necessitated training from the IPC team and have been assigned duties from the person in charge to ensure compliance with IPC standards and ongoing education of staff to ensure evidence-based practice is utilised within the centre. The person in charge oversees the completion of IPC link nurses assigned duties weekly.

• IPC link nurses continue to complete MEG audits and relay QIPs to all staff.

• Refresher training on completion of BARTHEL assessments ongoing onsite with nursing staff supported by practice development coordinator. Nursing staff have commenced HSELanD training on MUST assessment, PAL assessment training is ongoing for all staff by the practice development coordinator onsite. The person in charge is completing a weekly check on residents' clinical assessments to ensure an accurate reflection of the residents' current clinical presentation is recorded.

• All MTA/domestic staff assigned to domestic duties have certified CleanPass training on file.

• Cleaning schedule was updated to incorporate cleaning of trolleys and use of I am Clean stickers.

• Refresher training on cleaning standards, equipment decontamination procedures and infection prevention and control practices has been provided to all household staff by IPC team on 01/07/2026 during the IPC onsite walkaround.

• From 01/07/2026, Immediate supervision and competency assessments were commenced by the person in charge for all staff involved in cleaning practices.

• The practice development coordinator commenced an audit of all clinical assessments on 08/07/26 with the quality improvement plans discussed with nursing staff. The person in charge is reviewing the quality improvement plans to ensure actions completed are signed off.

• Education on Pain Assessment & Management in Older People is facilitated onsite to clinical staff by the practice development coordinator. This training commenced on the 08/07/2026 and remains ongoing to ensure all staff receive training.

• Pain assessment tools were reviewed for all residents and appropriate tools in place for assessment of pain. PRN analgesia effectiveness monitoring sheet commenced for all residents receiving PRN analgesia.

• All catering staff within the centre have completed IDDSI training and clinical staff have completing the IDDSI training on 21/08/2026.

Regulation 23: Governance and management	Not Compliant

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

• The person in charge and person participating in management have reviewed the management systems in place within the designated centre on the 30/06/2026 to ensure that the service provided to residents is safe, appropriate, consistent and effectively monitored.

• The person in charge and person participating in management are liaising with HR regarding the recruitment campaigns and process to replace existing vacancies within the centre. All vacant positions have been approved by local management and subject to the HR recruitment process. All vacant positions are backfilled with agency hours in the interim.

• The person in charge is utilising predominantly HSE framework approved agency providers to ensure all staff provided are compliant with the required training standards. This is applicable for all staff grades required by the centre. The person in charge has requested a clearance pass from all agency providers to ensure staff have the appropriate training and skilled to conduct their required role.

• The Person in Charge and person participating in management conduct regular reviews of staffing and workforce arrangements, including monitoring vacancies, leave, training compliance, and the use of agency staff. These reviews are reported to senior management as part of the centre's governance and management systems.

• The person in charge and person participating in management have reviewed the audit schedule on the 30/06/2026 and assigned staff to complete specific audits to ensure the effective identification and remedial of the deficits found in residents' assessments and in environmental and residents equipment cleaning practices. All audits are reviewed and signed by the person in charge. Audit findings will be reviewed at management meetings, and any identified quality improvement requirements will be addressed through supervision, education, and continuous quality improvement plans.

• The person in charge and person participating in management have received support from the IPC team in refining the domestic staff supervision, adhering to required infection prevention and control standards in the areas of cleaning of the floor surfaces, cleaner's carts, and residents' equipment. The 'I am clean' practice is reinforced within the designated centre by the person in charge and person participating in management to reduce the risk of cross-infection to residents.

• All MTA/domestic staff assigned to domestic duties have certified CleanPass training on file.

• The person in charge, person participating in management and practice development coordinator have commenced a review of all residents' care plan documentation and clinical assessments on the 30/06/2026. All residents Barthel assessments and MUST scores are an accurate reflection of the residents' current clinical presentation on the 09/07/2026. The residents revised Barthel and MUST scores were communicated to clinical staff during daily safety pauses.

• Refresher training on completion of BARTEL assessments ongoing onsite with nursing staff by practice development coordinator. Nursing staff have commenced HSELanD training on MUST assessment, PAL assessment training is ongoing for all staff by the practice development coordinator onsite. Twice a week, the person in charge is completing a review of one resident's care plans and clinical assessments, with nursing

staff, to ensure an accurate reflection of the resident's current clinical presentation is recorded.
• A medical officer attended the centre on the 01/07/2026 to prescribe the recommendations of the palliative care team. The residents pain management is monitored by staff through the ongoing completion of pain assessment tools and collaboration with the palliative care team.
• The person participating in management and registered provider attended a meeting with the centre's assigned medical officer on the 13/07/2026 to confirm the centre's medical officer requirements.
• The person participating in management and the registered provider escalated the speech and language therapist service requirement to the centre to the integrated healthcare area general manager, and residents received a SLT review on 09/07/2026.
• The person participating in management has liaised with the SLT manager regarding service provision. It is expected following recruitment, by the 30/09/2026 normal service will resume to the centre. The requirement for any residents SLT review is escalated to the SLT manager for assignment as required during this period.
• Pain assessment tools were reviewed for all residents and appropriate tools in place for assessment of pain. PRN analgesia effectiveness monitoring sheet introduced for all residents receiving PRN analgesia.
• All catering staff within the centre have completed IDDSI training and clinical staff have completed the IDDSI training on 21/08/2026.
• The person in charge on 11/08/2026 has introduced a resident review meeting that will take place twice weekly ensuring current information and recommendations are followed, and resident care is evaluation to ensure it is person centred and meets the needs of the resident. These meetings ensure that residents' current needs, assessments, and recommendations from healthcare professionals are reviewed and actioned in a timely manner. This process supports the ongoing evaluation of care plans, ensuring that care remains person-centred, accurately reflects residents' current needs, and provides clear guidance to staff to deliver safe and effective care.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The person in charge, person participating in management, registered provider and HSE estates in consultation with the Deputy Chief Inspector on 11/07/2026, discussed the proposed upgrade works to Room 15 which continues to have a condition assigned regarding occupancy by the regulator.
• It is expected the upgrade works will be completed by 30/11/2026.
• The person in charge has completed a review of the storage facilities within the centre on 30/06/2026.
• All equipment associated with the community occupational therapy service has been relocated to an external storage unit on 30/06/2026.
• The person in charge and/or delegate completed daily checks of internal rooms to ensure communal showers/toilets are free from inappropriate storage.

Regulation 27: Infection control	Not Compliant

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

• The person in charge and person participating in management overseen a deep clean of the entire designated centre on 30/06/2026.
• The person in charge and person participating in management have reviewed all practices and procedures, consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority within the designated centre on 30/06/2026.
• The person in charge and person participating in management completed a review of the staffing skill mix within the centre on 30/06/2026, and reassigned MTA's accordingly to ensure appropriate staffing is allocated to the domestic requirements of the centre.
• The person in charge and person participating in management have received support from the IPC team in refining the domestic staff supervision, adhering to required infection prevention and control standards in the areas of cleaning of the floor surfaces, cleaner's carts, and residents' equipment. The 'I am clean' practice is reinforced within the designated centre by the person in charge and person participating in management to reduce the risk of cross-infection to residents.
• The IPC link nurses within the designated centre have received the necessitated training from the IPC team and have been assigned duties from the person in charge to ensure compliance with IPC standards and ongoing education of staff to ensure evidence-based practice is utilised within the centre. The person in charge oversees the completion of IPC link nurses assigned duties weekly.
• IPC link nurses continue to complete MEG audits and relay QIPs to all staff.
• All MTA/domestic staff assigned to domestic duties have certified CleanPass training on file.
• Cleaning schedule was updated to incorporate cleaning of trolleys and use of I am Clean stickers.
• Refresher training on cleaning standards, equipment decontamination procedures and infection prevention and control practices has been provided to all household staff by IPC team on 01/07/2026 during the IPC onsite walkaround.
• The person in charge met with domestic staff to deliver and discuss the findings of 29/06/2026 inspection highlighting the floor cleaning in several areas throughout the centre did not meet the satisfactory and necessary standards.
• A review of the cleaning schedule was revised to increase x 2 domestic staff twice weekly to facilitate deep cleaning frequency of the centre.
• The person in charge and person participating in management completed a review of domestic products and storage areas within the designated centre on the 30/06/2026. All items were stored appropriately, with storages boxes/ areas cleaned, and all recyclable items disposed of accordingly. A deep clean of the two cleaner's cart's took place and this is now incorporated into a daily cleaning schedule for the domestic staff.
• The person in charge and/or delegate completes daily checks on cleaning equipment and cleaning trolleys.
• The person in charge and person participating in management completed a review of the laundry services on the 30/06/2026 with an additional service now scheduled each Monday morning. This ensures there is not large amounts of linen awaiting collection.
• The person in charge has requested access control to the door of the storage room to mitigate the risk of residents access to used linen awaiting collection. This is expected to

be completed by the 11/09/2026.

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 person in charge, person participating in management and practice development coordinator have completed a review of all residents' care plan documentation and clinical assessments commencing on 30/06/2026. All residents Barthel assessments and MUST scores are an accurate reflection of the resident's current clinical presentation and completed in line with evidence-based guidance on 09/07/2026. Where discrepancies were identified, assessments were immediately corrected and validated by the Person in Charge and/or delegate.

• Refresher training on the completion of care plan documentation and comprehensive clinical assessments, including MUST and Barthel assessments was facilitated for nursing staff on 01/07/2026 and 02/07/2026 by the practice development coordinator, with further dates scheduled monthly to ensure all nursing staff receive the training session. The person in charge completes a weekly check on residents' clinical assessments to ensure an accurate reflection of the resident's current clinical presentation is recorded.

• Residents care plans have been updated to reflect the recommendations of healthcare professionals including dietetic, speech and language therapy and pain management recommendations on 09/07/2026.

• 4 monthly reviews continue take place as standard with family/resident involvement.

• From 11/08/2026, the person in charge and or/delegate is attending resident MDT meetings every Tuesday and Thursday to complete an additional updated review.

• A medical officer attended the centre on 01/07/2026 to prescribe the recommendations of the palliative care team. The residents pain management is monitored by staff through the ongoing completion of pain assessment tools and collaboration with the palliative care team.

• The person participating in management and the registered provider escalated the speech and language therapist service requirement to the centre to the integrated healthcare area general manager, and residents received a SLT review on 09/07/2026.

• The person in charge and practice development coordinator completed a review of all resident's care plans relating to nutrition and swallowing against the most recent Speech and Language Therapy (SLT) and Dietitian recommendations on 09/07/2026. Care plans have been updated to accurately reflect current treatment plans and guidance provided by the multidisciplinary team.

• As part of the twice-daily Safety Pause, all recommendations from healthcare professionals are tracked to ensure they are incorporated into residents' care plans within 48 hours of receipt and reviewed for accuracy.

• The resident's pain management care plan has been reviewed and updated to provide clear guidance for staff regarding pain assessment, monitoring, reporting mechanisms,

and interventions required to manage pain effectively. Appropriate pain assessment tools are now being used for every resident to monitor pain levels consistently, and staff have been reminded of their responsibilities regarding documentation and escalation of concerns. Pain management care plans are reviewed regularly and following any change in a resident's condition. PRN analgesia effectiveness monitoring sheet introduced for all residents receiving PRN analgesia.
• Education on Pain Assessment & Management in Older People is facilitated onsite to clinical staff by the practice development coordinator. This training commenced on the 08/07/2026 and remains ongoing to ensure all staff receive training.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• A medical officer attended the centre on the 01/07/2026 to prescribe the recommendations of the palliative care team. The residents pain management is monitored by staff through the ongoing completion of pain assessment tools and collaboration with the palliative care team.
• The person participating in management and registered provider attended a meeting with the centre's assignment medical officer on the 13/07/2026 to confirm the centres medical officer requirements.
• The person in charge liaises with the palliative care team and other specialities as required to ensure residents have timely and appropriate access to clinical review.
• The designated centre is attended by the medical officer 5 days per week with Nowdoc providing a medical service to the centre for out of hours and weekend cover.
• The person participating in management and the registered provider escalated the speech and language therapist service requirement to the centre to the integrated healthcare area general manager, and residents received a SLT review on 09/07/2026.
• The person participating in management has liaised with the SLT manager regarding service provision. It is expected following recruitment, by the 30/09/2026 normal service will resume to the centre. The requirement for any residents SLT review is escalated directly to the SLT manager for assignment as required during this period where an identified community SLT will attend the unit to ensure timely access to SLT services.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The person in charge and practice development coordinator completed a review of all residents Passports on 07/08/2026, with interests prior to admission explored to ensure if they are currently relevant as per their activity level and how they are incorporated into their care plans.
• The centre has completed the Activity Survey with a quality improvement plan completed and displayed in the centre.
• The practice development coordinator commenced onsite PAL training in the centre for RNs and HCAs on 08/07/2026 with ongoing dates scheduled. The practice development coordinator completed a reassessment of all resident PAL levels.
• The person participating in management has identified additional resources for Meaningful Activities within the centre which commenced 13/7/2026.
• The person in charge and practice development coordinator commenced a review of all care plans reflect PAL level on 08/07/2026, ensuring inclusion of meaningful activities and residents will and preference
• There is a daily activity schedule displayed and visible for all residents within the centre, showcasing available activities throughout the morning, afternoon and evening period.
• Residents who prefer individual activities have a person-centred care plan which reflects their preference, daily evaluation of meaningful activities & residents engagement recorded in progress notes.
• The practice development coordinator has commenced on 08/07/2026 one to one care plan review in collaboration with RNs to support RNs with optimum care plan development.
• The person in charge is overseeing that all residents, including those who choose not to attend the centre's sitting room or group activities, will be supported to engage in meaningful social activities in accordance with their assessed needs, personal preferences, interests, and individual capacities.
• The person in charge oversees staff working with each resident to identify activities that are important to them and that promote their wellbeing, independence, and quality of life. Individual activity plans are developed and reviewed regularly to ensure they reflect residents' changing needs, choices, and abilities.
• Residents who prefer to spend time in their own rooms or in alternative areas of the centre are offered opportunities for one-to-one engagement and personalised activities each day. These include conversation, reading, music, arts and crafts, reminiscence activities such as old newspapers and books, sensory activities, walks, spiritual support audiobooks, library service, live entertainment, and other pursuits based on the resident's expressed wishes and interests.
• The Person in Charge maintains oversight of the implementation of individual activity programmes through regular review of care plans, activity records, resident feedback, and staff supervision. This ensures that all residents are afforded meaningful opportunities for social engagement and occupation consistent with their preferences and capacities on a daily basis.
• Through these measures, the person in charge is committed to ensuring that all residents experience a person-centred approach to social care and are supported to participate in activities that enhance their wellbeing and quality of life.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/11/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	17/08/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises	Substantially Compliant	Yellow	30/11/2026

	which conform to the matters set out in Schedule 6.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/09/2026
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	Red	03/07/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Red	11/09/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social	Not Compliant	Orange	13/07/2026

	care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	09/07/2026
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	09/07/2026
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a	Not Compliant	Red	13/07/2026

	high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Not Compliant	Orange	13/07/2026
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	30/09/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	13/07/2026