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:	Drumbear Lodge Nursing Home
Name of provider:	Newbrook Nursing Home Unlimited Company
Address of centre:	Cootehill Road, Monaghan
Type of inspection:	Unannounced
Date of inspection:	10 June 2026
Centre ID:	OSV-0005312
Fieldwork ID:	MON-0050753

About the designated centre

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

Drumbear Lodge Nursing Home is a purpose-built, single-storey centre situated close to Monaghan town. The centre provides accommodation for a maximum of 90 male and female residents aged over 18 years of age. Residents are accommodated in single, twin and one multiple occupancy bedroom with four beds. The centre provides long-term, respite and convalescence care for older residents, and residents with acquired brain injury, dementia and palliative care needs. The provider employs a staff team consisting of registered nurses, care assistants, maintenance, housekeeping and catering staff. The provider states that their objective is to provide a high standard of evidence-based care and ensure residents live in a comfortable, clean and safe environment to meet their needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	79

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 10 June 2026	07:40hrs to 18:30hrs	Geraldine Flannery	Lead
Wednesday 10 June 2026	07:40hrs to 18:30hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out by two inspectors of social services, which took place over one day.

Inspectors spoke with many residents, visitors and staff to gain insight into what it was like to live at Drumbear Lodge Nursing Home. The inspectors spent time observing the residents' daily life to understand their lived experience.

Overall, residents confirmed that they were supported to live comfortably in the centre and were adequately cared for by staff. Some residents and visitors called out staff by name saying they were 'like a mother', and that some staff were 'brilliant'. Other residents said that 'staff here are great', and they were ' all well looked after'.

However, residents and visitors said that there was a 'lot of new faces' in the centre. Inspectors were told that many familiar staff had left, and residents said that they 'miss them'. Several residents informed inspectors that they found it difficult to communicate with some staff, with one resident saying, 'they speak in a different language; I don't understand them, and they don't understand me'. One resident told inspectors that 'sometimes I have to wait a long time when I press the bell' and described the negative effect this had on their care.

On the morning of the inspection, during a walk around the centre at approximately 7.45 am while many residents were still in bed sleeping, the inspectors heard loud alarms ringing intermittently and repeatedly throughout the centre. Staff informed inspectors that it was from bed and floor sensor mats triggered in the resident bedrooms. Some staff informed inspectors that they hear the alarms day and night and 'didn't realise how loud and piercing it was until it was pointed out'. Inspectors noted that there was a high number of such devices in the centre, with 29 floor sensor alarms and 17 bed sensor alarms in situ.

On one occasion, when an alarm continued to sound, the clinical nurse manager (CNM) accompanying the inspectors was asked to locate a staff member to respond to the alarm to check if the resident was safe. The continuous exposure of staff to these alerts throughout their shifts created a risk that residents' needs would not be attended to in a timely manner. Staff had become desensitised by the volume and pitch of the alarms, reducing their awareness of the disruption and stress experienced by the residents. The inspectors observed a task-orientated approach to the morning routine rather than a person-centred approach.

Afterwards, inspectors observed that staff responded immediately to assist the residents; however, the noise impacted on the residents' right to a peaceful rest, quiet environment and a calm waking. It also potentially woke some residents ahead of their preferred schedule. Later in the day, inspectors heard the bell ringing on the

first floor, and when the inspectors queried why the call for assistance was not responded to, they were informed that the alert related to the ground floor.

While there were no specific complaints about the sound of the alarm ringing, one resident said the centre 'can be loud at times'. Inspectors brought the matter to the attention of the management, so that the call-bell and alarm system could be reviewed.

The lived-in environment was warm and clean throughout, however some resident equipment appeared unclean and will be discussed later in the report. There were signs of general wear-and-tear in the centre, including chipped paint on interior walls and scuffed woodwork.

When asked about their food, all residents who spoke with the inspectors said that the food was very good. They said that there was always a choice of meals, and it was always hot and tasted good.

On the first floor, some residents at the lunchtime service informed the inspectors that they had forgotten what they had ordered. There was no menu on display on the tables or in the dining room. This was quickly corrected and a menu in a small print format was placed on the notice board, which did not support residents with communication difficulties.

Adequate numbers of staff were observed in the dining room and familiar staff were seen to be creating a home-like atmosphere sharing warm-hearted and lively chats with the residents; however, inspectors also noted that there was little conversation or engagement observed between some staff who were providing assistance to residents with their meals.

Inspectors saw jugs of water and juice delivered to residents' bedrooms, and staff ensured that residents always had access to adequate drinking water throughout the day. However, the accompanying plastic beakers that residents had to drink from appeared visibly worn, and had writing that was faded from repeated use. This did not always support a pleasant dining experience.

There was an activity schedule in place that reflected the activities taking place while the inspectors were present. The inspectors observed group activities, which the residents appeared to enjoy. Residents spoken with said that activities were mostly good but said 'they could be better'. Inspectors observed that there were long periods of time where some residents sat in their bedrooms alone, with minimal opportunities for engagement and activation.

Some staff who spoke with inspectors said they felt 'tired'. They reported that the high staff turnover contributed to instability within the centre. Some staff reported feeling frustrated at the lack of staff supervision, which contributed to poor practices relating to resident supervision and inaccurate record-keeping occurring at times.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre and describe how these arrangements support the quality

and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations.

Capacity and capability

The findings from this inspection were that the registered provider had failed to ensure that there was a clearly defined management structure in place, with clear lines of accountability and responsibility, in line with the centre's statement of purpose.

There was no person in charge present on the day of inspection, as required by the regulations. The Chief Inspector of Social Services had been notified of a third change in the person in charge within one year. As a result of frequent changes in the person in charge the overall stability of the governance and management arrangements in the designated centre was impacted.

The inspectors found that the regulatory compliance for the centre continued to deteriorate since the previous inspection in October 2025 and was adversely impacting residents' right to a high standard of safe quality care, as further detailed in the report.

The inspectors acknowledge that the provider took prompt action on the day of inspection and restored the governance and management structure by appointing a new local management team, which included the assistant director of nursing (ADON) being appointed as the person in charge (PIC).

Inspectors found that given the weakened governance and management structures in place, there were failings in supervision of staff, and in the systems of monitoring the service. Significant action by the provider was now necessary to ensure the effective and safe delivery of care.

This was an unannounced inspection. The purpose of the inspection was to monitor regulatory compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended).

The registered provider is Newbrook Nursing Home Unlimited Company. An assistant director of nursing (ADON) facilitated the inspection supported by the clinical operations manager.

Notwithstanding that there were sufficient numbers of healthcare staff on duty on the day of inspection, there was insufficient clinical supervision in place to ensure that residents' needs were met in a timely and person-centred manner, as further evidenced under Regulation 5: Individual assessment and care plans.

Since January 2026, there had been a high turnover in staff for all roles; 24 staff left and 19 new staff started in the centre. This impacted on the ability of the governance and management team to stabilise and effectively supervise staff practices to ensure the provision of high quality and safe care.

The management systems of oversight were inadequate. While key performance indicators were being monitored, there had been little to no audits carried out in the previous six months, even in areas where non-compliance had been identified during the previous inspection. Where audits were completed, they were not representative as the sample used was very small, and they were not accompanied by an action plan and assigned to a nominated responsible person. This is further described under Regulation 23: Governance and management.

There was a training matrix in place that set out when each staff member had completed training, and when they were due to complete refresher training. Inspectors saw that training was scheduled to be provided in the coming days for care of the deteriorating adult and end of life care. Additional relevant training recently completed by staff included medication management, pressure area care, restrictive practices and behaviours that challenge.

Notwithstanding the training provided, inspectors found that the supervision arrangements at the centre were not effective to ensure the principles of the training received were consistently implemented in practice, as further detailed under regulation 16: Training and staff development.

Registration Regulation 6: Changes to information supplied for registration purposes

Notwithstanding that the provider had given notice in writing to the Chief Inspector of Social Services, of the intended change of the person in charge, within 10 days of it occurring; full and satisfactory information, as set out under Schedule 2, was not provided as required.

Judgment: Not compliant

Regulation 14: Persons in charge

There was no person in charge in the centre; the person who was notified to the Chief Inspector as the person in charge had resigned.

Judgment: Not compliant

Regulation 15: Staffing

On the day of the inspection, there were adequate levels of nursing and care staff on duty to ensure the safe delivery of care to residents. All nurses held a valid Nursing and Midwifery Board of Ireland (NMBI) registration.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents at all times. This was evidenced by the failure to;

- Provide effective oversight of the residents' clinical documentation to ensure that residents' assessments and care plans were implemented in practice.
- Ensure nursing care records were appropriately maintained and reflected the care provided to residents on a daily basis.
- Provide effective oversight of staff training and competency gaps to ensure awareness relating to all aspects of care delivery including infection prevention and control (IPC) practices, which may pose a risk to resident safety and infection prevention standards.

Judgment: Not compliant

Regulation 21: Records

The registered provider ensured that the records set out in Schedules 2, 3 and 4 were available to the inspectors on the day of the inspection, and the management of the records was found to be in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not ensured that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose, as evidenced by;

- The registered provider did not ensure that the management structure was maintained in line with the centre's statement of purpose and regulatory requirements. There was no person in charge in the centre.

The registered provider did not have effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- A finding of the previous inspection was that class A controlled drugs were not always signed by two individual staff nurses twice daily, which was not in line with the centre's own policy and best practice. Inspectors found that while in general there were two signatures, there continued to be a number of gaps in these records, and this had not been identified or addressed by the provider. There had been no medication audits completed by management in 2026.
- There was no documentary evidence of recent pharmacy audits being carried out. The inspectors were informed the provider had changed the pharmacy service in November 2025 and management were not aware of the latest pharmacy audit results.
- Staff supervision was not sufficient to ensure the effective and safe delivery of care relating to pressure ulcer management. Inspectors sat in the morning handover where the needs of the residents were communicated clearly, including those who required enhanced monitoring, regular repositioning and increased fluid intake. However, a review of residents' records showed no evidence that these tasks were consistently implemented or, where they were completed, the time stamp was not contemporaneous. For example, in the case of one resident all repositioning records for the night were signed at 6 in the morning.
- Clinical oversight and staff supervision was insufficient to ensure staff implemented the local policies and protect the residents against unsafe practices. For example, medication was not administered in line with professional guidelines and was not in line with local policy; the 10 rights of medication administration were not consistently followed to protect the residents. Inspectors saw examples where medication was administered based on an email from the GP, which did not include the allergy status of the resident, the administration times or the route of administration. This included administration of high-risk medicines such as controlled drugs. This practice posed a significant risk of errors and impacted residents' safety.
- The quality of audits conducted in some areas were very poor. For example, several care planning audits completed had a sample of one care plan reviewed, and the audits failed to identify areas for improvement or generate meaningful action plans to improve practice.
- Despite findings of concern regarding restrictive practices, identified during the inspection in October 2025, no action was taken to review if the training provided to address these issues had been implemented in practice or resulted in any improvements.
- Management oversight of staff practices in respect of infection prevention and control was not sufficient. For example, despite the daily cleaning schedules for medicine fridges signed as having been cleaned, were seen by

inspectors to be visibly unclean. Further evidence is provided under Regulation 27: Infection Control.

- Greater management oversight was required out-of-hours. For example, inspectors observed an instance where a resident's alarm bell went unanswered and the resident was left without assistance until inspectors asked the CNM to locate staff.
- Local audits and environmental walk-arounds had not identified that call-bells were ringing in all areas of the centre instead of alerting only the responsible staff for a particular area. A sample of call bell audits reviewed were not meaningful, as they did not record the response time. While a more robust audit tool had been introduced, at the time of this inspection there had been no audit carried out using the revised tool.
- The provider had not completed all actions committed to in a compliance plan submitted following the last inspection with repeated findings in several regulations. In addition, where the provider had put measures in place outlined in their previous compliance plans some gaps were noted in the documentation. For example, the provider had committed to including water flushing records on the housekeeper's checklist to give assurance that the risk of Legionella bacteria in the water system was being managed appropriately, however inspectors observed gaps in the record.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations, however not all policies were consistently implemented in practice. For example:

- Wound management policy
- Medication management policy
- The use of restraint

This is a repeat finding.

Judgment: Not compliant

Quality and safety

The overall quality and safety of care was significantly compromised by the weakened governance and management and failures of oversight, as detailed in the Capacity and Capability section of this report. Failings were found in key regulations

underpinning quality and safety including medication management, care planning arrangements, healthcare, managing behaviour that is challenging, infection control and residents' rights.

Care planning documentation was available for each resident in the centre, however significant improvement was required. The inspectors reviewed a sample of residents' care plans related to safeguarding, nutrition, falls management, skin integrity, mobility, restrictive practices, safeguarding and behavioural care plans and found that while some care plans were person-centred, they were not effective at guiding care and were not consistently implemented in practice, as further detailed under regulation 5: Individual assessment and care plan.

There was access to a general practitioner (GP) and referrals were made to specialist professionals in line with residents' assessed needs, however action was required by the provider to ensure a high standard of evidence based nursing was provided as further detailed under regulation 6: Healthcare.

Notwithstanding that staff had received training in the management of restraints and responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), inspectors found that staff lacked clear understanding of what constituted restraint. The use of restraints was monitored within the restraint register, however there was confusion among staff between a restrictive practice and an enabler. Behavioral care plans were in place, but they were very wordy and long did not consistently include the interventions and de-escalation techniques required to support the residents.

Residents' nutritional and hydration needs were met. Inspectors observed that residents' dietary needs and preferences were respected, and there were appropriate systems to communicate specific dietary needs to all staff. However, there were many opportunities for improvement in respect of serving of food to ensure residents' mealtime experience upheld residents' rights.

Inspectors observed that some practices in respect of infection prevention and control, were not consistent with the *National Standards for Infection Prevention and Control in Community Services (2018)* and and the compliance plan from the inspection in October 2025 was not completed.

Regulation 17: Premises

Overall the premises was of suitable size to support the numbers and needs of residents living in the designated centre. The inspectors followed up on the compliance plan from the previous inspection and found that there was appropriate ventilation and heating in place in the designated centre. Both clinical rooms had a working thermometer, and the temperature was documented daily and did not exceed medication storage recommendations.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents had access to safe supply of fresh drinking water at all times. They were offered choice at mealtimes and were provided with adequate quantities of wholesome and nutritious food.

Judgment: Compliant

Regulation 27: Infection control

Action was required to ensure that the centre complied with procedures consistent with the *National Standards for Infection Prevention and control in Community Services (2018).* For example;

- There was a lack of assurance in respect of the safe management of sharps; a sharp bin on the ground floor had not been signed as per the policy for traceability purposes.
- Single use dressings were observed to be open and partly used, and stored with un-opened products, which could result in them being re-used and posed a risk of cross-contamination.
- Some staff did not recognise the single use symbol and failure to follow the guidelines may increase the risk of transmitting infection between residents.
- The cleaning processes in the centre were not in line with best practices. For example, the medication fridge in two clinical treatment rooms were visibly dirty and blood staining was observed on a phlebotomy tray. This posed a risk of cross-contamination.
- Clinical waste bags were observed inside non-risk labelled bins in two sluice facilities.

This is a repeat finding.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication management practices were not in line with best practices or local policy, which led to some unsafe practices. For example:

- Class A controlled drugs were not always signed by two individual staff nurses twice daily, which was not in line with the centre's own policy. This is a repeat finding.
- Medication was not administered in line with best practice, within one hour of the prescribed administration times. Inspectors saw numerous examples of medication prescribed for 9am being administered at 7am in the morning, or evening medication rounds being completed by day staff at 19:00 hrs instead of 21:00 as prescribed.
- The storage of medication was not always in line with best practice. For example, inspectors observed opened insulin pens in use by residents being stored in the fridge; this was against the indications of storage for this product as identified on the medication box.
- Crushing orders were not always identified in respect of each medication, and were haphazardly implemented; in their conversation with inspectors staff nurses detailed how they would crush some medications for which there was no crushing order in place, which may pose a risk to the resident or the efficacy of the medicine. This is a repeat finding.
- Medication that was no longer required by the residents was not timely returned to the pharmacy. This included medication for two residents who had been long discharged from the centre, and controlled drugs in respect of two other residents who had died in the previous month.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans did not provide appropriate guidance to staff as there were many inconsistent or conflicting entries. For example, one care plan stated that resident's malnutrition risk assessment (MUST) score was 0 (low risk) and also 1 (medium risk), and that the resident was for monthly/weekly weights. Another care plan outlined the interventions required to support the pressure area care as repositioning every 2 hours but also every 90 minutes. There was little evidence of repositioning being carried out.
- Not all care plan interventions were implemented in practice. For example,a resident with a MUST score of 2 (high risk) following assessment, had identified in the care plan that weekly weights were required, however these weights were completed on a monthly basis; a resident assessed at high risk of absconsion required to have enhanced 30 minutes safety checks, however there had been only one such check recorded in the previous three days.
- Some residents' care plans contained historical information which was no longer relevant and could lead to confusion regarding the most relevant plan of care. For example, the pressure area care management of a resident described that a resident had two different types of dressings in place. The

resident no longer required any of these dressings however the care plan had not been discontinued and not updated. Other wound management care plans seen were excessively wordy and did not provide clear guide on the dressing regimen or the frequency of change, as recommended by the tissue viability specialist.

- Some care plans were very wordy and lengthy, with valuable information buried within the text. Many were retrospective, chronologically detailing incidents that had occurred and failed to describe the interventions required to guide practice and meet residents' current needs going forward. This included safeguarding and responsive behaviours care plans that did not outline any supportive interventions just the specifics of incidents that had occurred in the centre.
- Not all care plans had been reviewed in the previous four months. For example, the care plan for a grade 3 pressure sore had not been reviewed since December 2025, a care plan for the risk of absconsion had not been updated since January. There were examples of other care plans, such as end-of-life care plans that had not been populated at all in some instances.
- Many care plans were generic, relying on a template that was left blank.

Judgment: Not compliant

Regulation 6: Health care

Notwithstanding the availability of access to general practitioner (GP) and a team of allied healthcare professionals, a high standard of evidence-based nursing care was not consistently provided, as evident by:

- Neurological observations were not always carried out following an unwitnessed fall to ensure prompt action would be taken in the event of head injury. The inspectors saw evidence of vital signs checked but not neurological observations as required by local policy and best practice.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

While staff had training in responsive behaviours, the oversight of restrictive practices was not sufficiently robust to ensure that staff had sufficient knowledge and skills to manage behaviours that challenge. Even though the local policy clearly differentiated between an enabler and restraint, in their communication with inspectors and from a review of a residents' documentation and care plans there was a lack of understanding of the principles of training. For example:

- Sensor alarms, wander tags, lapbelts were considered enablers instead of restricting the residents' freedom of movement.
- Although there was only one bedrail in use in the centre, almost one third of the residents had sensor alarms in place, which was not in line with the national policy towards a restraint-free environment.
- Records showed that the decision to introduce a restrictive practice was not always a clinical decision informed by a multi-disciplinary team (MDT). In one example, the inspectors saw records showing that family had requested the restraint without any MDT input.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not ensure that each resident's rights were upheld at all times, as evidenced by the following;

- Loud pitched alarms ringing throughout the centre did not maintain a calm, home-like environment, failing to respect the comfort of residents.
- Inspectors found that some residents who chose to stay in their bedrooms or those with higher levels of social and cognitive needs, were not adequately supported to participate in meaningful social activities to meet their interests and capacities. This was a repeat finding from the previous inspection.
- Plastic glasses given to residents in their bedroom were clean and while functional, they appeared excessively worn and neglected and did not support residents' dignity.
- The residents' rights to know what meals were served and make informed choices was compromised; the only menu in a dining room on the first floor was a small notice pinned to a notice board that many residents could not see, particularly those with visual impairments.
- Some residents that were assisted with their meals and refreshments, were not supported in a person-centred way. Support provided appeared to be task-focused, rather than a social and dignified experience, with little or no interaction.

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	
Registration Regulation 6: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Drumbear Lodge Nursing Home OSV-0005312

Inspection ID: MON-0050753

Date of inspection: 10/06/2026

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**
Registration Regulation 6: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: The Provider has submitted all information as set out under Schedule 2 to the chief Inspector.	
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The center has a Person in Charge (PIC) that meets the requirements.	

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 Nursing Home Management Team will supervise the care and welfare of residents at all times.
• The PIC and nursing management team will guide, direct and oversee Residents clinical documentation daily.
• The Practice Development Officer (PDO) will work on site with Nurses a minimum of 2 days a week to educate, guide and supervise documentation.
• All Nursing assessments, Progress notes and Care plans will reflect the care required, provided and delivered to residents.
• The PIC will review the current staff training and identify gaps through supervision of practice and audit.
• IPC: The PIC has completed the IPC Course. The CNM will attend the next IPC course. All staff will have mandatory IPC training.
• IPC practices have been reviewed and a comprehensive IPC audit completed with actions in progress.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Management Team is in line with the center's Statement of Purpose with a Person in Charge and Senior management team.
In addition to the Person in Charge onsite (5 days a week), the following additional supports have been introduced:
Clinical Operations Manager: Onsite 4 days a week.
Practice Development Officer: Onsite 2 days a week.

• Medication: The Nurses have attended medication Training. The CNM's will supervise the Controlled Drugs book and report to the PIC. Medication Audits will be completed with any deficits, actions and learning.
• Pharmacy: The Pharmacist will complete a schedule of Pharmacy Audits for 2026 with actions and quality improvements.
• The PIC will supervise Pressure Ulcer care and delivery through observation, supervision, monitoring and daily checks on documentation and practice.
• Skin Integrity care plans will be guided and directed by the TVN, supervised by the PIC and implemented by the CNM and nursing team. The Care Plan will direct the current dressing plan and repositioning schedule for each resident.
• The PIC and Senior nursing team will provide clinical supervision of nursing practice in

line with Medication policy and NMBI guidelines. The Practice Development Officer will complete medication Competency on all Nurses. All medication will be administered in line with the NMBI Guidance for Registered nurses.
• Care Plan audits will be completed using a 10% sample measurement.
• Restrictive Practice has been reviewed; the Restrictive Practice Trainers have been updated with the Current Policy and will support and guide staff daily in the Centre. The Restrictive Practice audit will reflect any deficits, actions or quality improvements planned and completed.
• The Nurses will complete and sign the daily cleaning checks for the medication fridges and all Clinical room checks. The CNM' will supervise this practice and report to PIC.
• The PIC and Senior management team will conduct daily walkarounds in the center to ensure a high standard of nursing care is delivered daily.
• The Clinical Operations and PIC will conduct out-of-hours spot checks and document visits, findings, actions and quality improvements.
• Supervision at weekends will be adjusted to strengthen Nursing oversight to achieve a high standard of safe quality care .
• Call Bell Audits will be completed at different times of the day; the call bell system will be reviewed. A call bell audit tool will show a 10% sample measurement with learning
• The Provider, PIC and Clinical Operations Manager will complete all actions from the previous inspection.
• The Legionella records will be updated and supervised weekly by the head housekeeper. The Head Houskeeper will report current records and any new risks to the PIC.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The PIC will ensure that all Schedule 5 Policies are implemented in practice.
• The Practice Development officer will complete Clinical competency assessments for Nurses and report to the PIC with any deficits.
• Short Daily "Policy Refresher Talks" will be introduced daily at handover meetings; these will serve as a Policy refresher to ensure that all staff understand and are confident delivering a high standard of care to residents.

Regulation 27: Infection control	Not Compliant

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

• All Nurses will complete Sharps Awareness Training.
• All Nurses will be aware and follow the single use Dressing procedure in line with IPC guidelines and best practice to prevent Infection. The CNM's and PDO will supervise Nurses Practice.
• All Nursing staff will be reminded and conform to the Single use symbol and implement in practice daily.
• The CNM will supervise and audit the Clinical room areas including Medication fridges and all audit the storage and cleaning of all equipment.
• All Sluice rooms will have Clinical waste bins with Clinical waste bags in line with IPC Policy.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• All Nurses will repeat Medication Management Training.
• The PDO will complete a Medication Competency for all Nurses.
• The PIC will discuss and review the medication administration times with the GP and Pharmacist to ensure medication is administered within the recommended one-hour window.
• Medication storage has been reviewed, and Insulin will be stored in line with manufacturers guidelines
• Nursing staff will follow Residents crushing orders, any residents who require a review will be prioritized by the PIC at the time or at the Medication review to ensure accurate documentation and administration and eliminate any risk for residents.
• The CNM and nursing team will check daily and return medication daily to Pharmacy where no longer in use or required by residents.
• The nursing management team will complete a monthly medication audit.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The PIC will oversee the Residents Care plans in line with regulation. All residents will have a Care Plan that is up to date and reviewed at a minimum 4 monthly to accurately outline and direct a high standard of nursing care.

• The PIC and senior nursing team will audit care plans Training and provide training and support to Nurses
• Care Plan support will be organized and delivered for the Nurses by the Practice Development Officer on site using a personalized named nurse approach.
• All Care plans will guide interventions, and the PIC and senior nursing team will observe and supervise the delivery practice daily. Safety checks will be checked and updated to reflect residents' needs and practice. Care Plans with historical data will be updated by the named nurse.
• Skin Integrity care plans: Pressure ulcers and wounds will be referred to the TVN and the recommendations for the interventions and care delivery instructed in the care plan.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• The PIC will conduct Falls Audit and check all Neurological assessments have been completed in line with the Falls Policy.

• All Nurses will have a clinical competency assesement completed by the PDO to assess knowledge and practice. The PDO will give report findings to the PIC.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• The PIC will review the Restrictive Practices in the Centre and check that they are in line with the centers own policy.
• The principles of training and the knowledge of staff will be assessed to ensure there is no ambiguity or gap between staff knowledge and staff practice.
• The Residents Sensor alarms will be reviewed weekly at the Restrictive Practice committee meeting attended by the CNM and Physio. Where possible the Centre will reduce the current equipment to achieve a Restraint free environment.
• Restrictive devices that Residents are using will be documented clearly in the care plan with documented plan for Log and release.
• Restraint Logs will be completed
• Restrictive Practice Decisions will show documented evidence of MDT input in line with policy.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• A New Fall Reduction Sensor Alarm Systems will be trialed with an emphasis on exploring any sound sensitive options that could reduce noise pollution for residents in the Centre.
• The PIC will review the current Activities Schedule with particular focus on those residents who choose to stay in their bedrooms .The Activities Team will reassess Residents who chose to stay in their bedrooms and document preferences and interests reflected in a Room visit plan for those residents .Where some residents make take the opportunity to avail of individual Room visit Activities ,other residents may attend smaller group activities .All assessments ,choices, preferences and Activity plans and participation will be documented.
• Plastic Drinking Glasses will be replaced.
• Mealtimes Menu and Times will be updated to have improved visual access to all residents. The Chef will conduct a walkaround in each Dining Room after mealtimes at a minimum of once a week to view the mealtime delivery service.
• A mealtime experience audit will be conducted; results will be communicated with staff. Staff will receive additional on-site dysphagia and food and nutrition training. The CNM /Nurse will supervise mealtimes. All staff will assist residents with interaction using a person-centered approach to ensure a meaningful experience.

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
Registration Regulation 6 (1) (b)	The registered provider shall as soon as practicable supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of the new person proposed to be in charge of the designated centre.	Not Compliant	Orange	11/06/2026
Regulation 14(1)(a)	The registered provider shall ensure that the designated centre has a person in charge.	Not Compliant	Orange	11/06/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2026
Regulation 23(1)(a)	The registered provider shall	Not Compliant	Orange	30/09/2026

	ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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	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	Orange	30/09/2026
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	Orange	30/09/2026

Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	30/09/2026
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	30/09/2026
Regulation 04(1)	The registered provider shall	Not Compliant	Orange	30/09/2026

	prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	30/09/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/09/2026
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 high standard of evidence based nursing care in accordance with professional	Substantially Compliant	Yellow	30/09/2026

	guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	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	30/09/2026
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	30/09/2026