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:	Sonas Nursing Home Tullow
Name of provider:	Sonas Nursing Homes Management Co. Limited
Address of centre:	Shillelagh Road, Tullow, Carlow
Type of inspection:	Unannounced
Date of inspection:	15 July 2026
Centre ID:	OSV-0005417
Fieldwork ID:	MON-0050239

About the designated centre

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

Sonas Nursing Home Tullow is a purpose-built, single-storey residential service for older persons. The centre is situated a short driving distance from Tullow town in a village community setting. The centre provides accommodation for a maximum of 60 male and female residents aged over 18 years of age. Residents are accommodated in single bedrooms throughout, each with en-suite shower, toilet and wash basin facilities. The centre provides long-term, respite and convalescence care for residents with chronic illness, residents with an intellectual disability, acquired brain injury, dementia and palliative care needs. The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 July 2026	08:30hrs to 17:35hrs	Aoife Byrne	Lead
Wednesday 15 July 2026	08:30hrs to 17:35hrs	Niamh Moore	Support

What residents told us and what inspectors observed

This was an unannounced inspection, carried out over one day, by two inspectors of social services. The inspectors met with many residents who were living in the centre and based on observations and discussions it was evident that Sonas Nursing Home Tullow was a nice place to live. Staff were seen to be familiar with the residents' needs and preferences, and were observed to be respectful in their interactions with residents.

Sonas Nursing Home Tullow is a purpose built, one storey premises located in Tullow, Co. Carlow. The centre is registered to provide care for a maximum of 60 residents with five vacancies on the day of the inspection. All bedrooms were single rooms with en-suite bathroom facilities.

On arrival the inspectors spent time walking through the centre, which provided an opportunity to introduce themselves to residents and staff. Some residents were observed to be up and about in the communal area, while others were observed sleeping in their beds or waiting for breakfast to be served to them in their bedrooms.

The premises was found to be clean, well maintained and homely on the day of the inspection and was seen to be supported by a maintenance and housekeeping team. However, inspectors observed an assisted bathroom was locked, which restricted free-access to the only bath available for residents. It is acknowledged that this bathroom was freely accessible by the end of the inspection.

There were notice boards which displayed advocacy service details and the activities schedule. Inspectors reviewed the planned activity schedule, and found that many activities outlined for the week were repetitive, with rosary occurring for seven out of the total of 21 activities, and an exercise class and quiz planned for a further five out of the 21 activities. Inspectors saw that there were minimal activities available for residents who preferred to spend most of the day in their bedrooms, with limited records of one-to-one activities. Inspectors saw that residents had given similar feedback in surveys with comments such as "would like to do more excursions", "would love more live music", "staff to visit more" and "I don't get to talk to people much". One resident when spoken with inspectors regarding the activities available, said "there is a lot on religion". This will be further discussed within this report.

The daily menu was displayed outside the dining room which outlined the meal options for breakfast, mid-morning snack, lunch time, mid-afternoon snack, the evening meal and supper. Inspectors observed the dining experience and saw that some residents were eating in their bedrooms, while some chose to eat in the dining room. During the lunch time service, residents were given a choice of two options on the day of the inspection, beef stroganoff or chicken curry and rice. Dessert was pear apple and cinnamon sponge with custard or stewed rhubarb and custard.

There were adequate levels of staff to support residents, and those who required assistance with their meals, received support from staff in a respectful and dignified manner. Inspectors saw four residents being served their meals in the lounge room. The residents here who could eat independently had their meals placed on overbed tables and were sitting slouched in armchairs which did not provide good postural positioning for eating. Meals were well-presented, and there was a choice of drinks also available. Residents who spoke to the inspectors were complimentary regarding the food provided, reporting that the temperature of the food was appropriate and they got sufficient portions. One resident reported they didn't like what was on the menu on the day of the inspection and was offered another choice. One visitor mentioned that at times when the soup was delivered to their family members bedroom it was occasionally quite hot.

On the day of the inspection the atmosphere in the centre was calm and relaxed. The inspectors observed that staff and residents interactions were found to be person centred, kind and respectful. The inspectors spoke with residents and visitors who were very complimentary in their feedback and expressed satisfaction with the care, staff, food and that they felt safe and that they were content living in the centre. Overall, residents said that staff were kind and attentive to their needs "they are all very nice and would do anything for you".

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

Capacity and capability

The inspectors found that the provider had progressed with the majority of actions set out in their compliance plan following the last inspection, and this inspection found improvements in some areas of the regulations. Notwithstanding this, there were gaps identified in areas such as staff training, contracts of care, notification of incidents, complaints and management systems.

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). This inspection also followed up on the compliance plan from the last inspection in November 2025 and reviewed solicited information. This included unsolicited information received by the Office of Chief Inspector relating to some of the governance and management systems in the centre including poor discharge planning. This information was found to be substantiated on the inspection. As a result, the provider was invited to a warning meeting in relation to concerns regarding the poor discharge planning and arrangements in place which was seen to impact on a resident. This will be

discussed under Regulation 6: Healthcare and Regulation 25: Temporary absence or discharge of residents.

Sonas Nursing Home Tullow is operated by Sonas Nursing Homes Management Co. Limited who is the registered provider of this designated centre. Since the last inspection, there has been changes to nursing management. A new person in charge commenced in January 2026, and a new clinical nurse manager started a few months later. There was no assistant director of nursing since January 2026, however following a recruitment campaign a suitable candidate was appointed and due to start in their role in August 2026.

The registered provider had monitoring systems in place to oversee the service such as meetings and auditing.There was an audit schedule available and actions were found to have been taken from the audit findings. The registered provider had completed an annual review of the quality and safety of care delivered to residents in 2025. There was evidence of consultation with residents, and an action plan put in place to respond to areas for improvement identified for 2026.

There was an extensive suite of training available to all staff in the centre with an ongoing schedule. However, there were gaps observed in mandatory training, this is discussed under Regulation 16: Training and staff development.

Records maintained in the centre were in paper and electronic format. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available for each member of staff. There was a record of current registration details for all staff nurses with the with the Nursing and Midwifery Board of Ireland.

Some notifiable incidents which had occurred in the centre, including incidents of alleged abuse, unexpected death and pressure ulcers had not been notified to the Chief Inspector in line with the requirements of the regulations. This is further discussed under Regulation 31: Notification of Incidents.

The centre had a complaints policy that was in line with the regulations. However, the complaints policy and complaints procedure that was displayed in the centre did not match, this is discussed further under Regulation 34: Complaints procedure. The inspectors reviewed a sample of both verbal and written complaints and saw that they had all been dealt with appropriately. Residents were aware of the policy in place for managing complaints and told inspectors that they felt safe and supported to raise any concerns with the staff team.

Regulation 16: Training and staff development

Staff had access to mandatory training, however not all staff were up-to date with their training. For example

- 15% of staff had not completed fire safety training.

- 18% of staff had not completed up to date safeguarding training.
- Following up on the compliance plan from November 2025 inspection, all nursing staff were due to complete refresher care planning training by April 2026, however, 73% of staff had not completed this.

Judgment: Substantially compliant

Regulation 21: Records

Records were maintained in the centre in a secure but easily accessible format. All required documents for each staff member were made available and found to be compliant with the regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

Management systems to ensure that the service provided was consistent and effectively monitored were not sufficiently robust. This was evidenced by the following:

- Oversight and management systems in place to ensure that residents received appropriate pre-admission assessment, planned and safe discharge and timely referrals to health care professionals was insufficient.
- Review and analysis of incidents within the designated centre did not consistently inform quality improvement measures. For example, inspectors reviewed a sample of three unwitnessed falls and found that post falls assessment had not been completed correctly, and that the falls protocol policy had not been adhered to. These deficits had not been identified through the providers oversight systems, as an incident report for one of the falls had been signed off as confirming that policies had been adhered to.
- Inspectors were not assured that all records were accurate. For example, a resident had a record of attending chiropody services a week prior to the inspection. However, the resident told inspectors that their toe nails were sore and visually they did not appear to have been cut and trimmed recently. This was raised with management on the day of the inspection.
- Management systems in place to ensure that the required notifications were submitted to the Chief Inspector within the specified timeframes outlined in the regulations, were insufficient, as further detailed under Regulation 31: Notification of incidents.
- The providers oversight systems had not identified that two oxygen cylinders stored in a residents' bedroom had no signage to alert the presence of oxygen in the room.

- There was no robust review and risk assessment available to inspectors on the day of inspection in relation to the reduction in general practitioner (GP) access, which is not in line with the service level agreement made with the GP.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed records in relation to contracts for the provision of services and found that one contract had not been signed since admission in August 2025.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not submitted all notifiable incidents within two working days of their occurrence as set out under Schedule 4 of the regulations. It is acknowledged, following communication with the provider that four notifications were submitted late.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy available which was up to date and contained the requirements of the regulations, however the procedure displayed in the centre did not match the process outlined in the policy. The procedure was not displayed in prominent areas throughout the centre for both visitors and residents to avail of.

Judgment: Substantially compliant

Quality and safety

Residents in Sonas Nursing Home Tullow appeared content living in the centre and many spoken with said they were happy with the care they received. The inspectors

observed that the staff treated residents with respect and kindness throughout the day of the inspection. However, inspectors identified that actions were required to ensure a safe and good quality service was consistently provided for residents in relation to ensuring assessed needs were met, healthcare, safeguarding residents and activity provision.

A sample of electronic residents' assessments and care plans were reviewed. Overall inspectors found improvements in the care planning arrangements since the last inspection where regulatory timeframes were met for completing assessments and care plans, and most of the documentation was updated as required or within the last four months. However, inspectors saw that residents' needs were not always met in line with their assessments and care plans. This is further discussed under Regulation 5: Individual assessment and care plan.

Overall residents had access to medical care. A GP attended the designated centre twice a week. Outside of this an out of hour's service was contacted. There was evidence from a review of residents' records that residents were reviewed by health and social care professionals, for example by a physiotherapist, speech and language therapist, optician and chiropody. However, inspectors identified that one resident who was seen by a specialist geriatrician nurse, had not been referred to their GP for the relevant follow up as recommended. This is discussed further under Regulation 6: Healthcare.

A sample of safeguarding incidents were reviewed and seen to have been referred to the appropriate external agencies, for example the safeguarding and protection team. However, inspectors reviewed three safeguarding care plans, and all were generic and did not provide details of each resident's specific care needs. This created a risk that staff would not have access to relevant and appropriate information in residents care plans to provide appropriate care for residents.

Overall, inspectors observed that staff upheld residents' rights. They were observed to be patient and kind to residents, and residents reported overall being content living in the centre. Residents' meetings were held monthly to enable residents to have the opportunity to provide feedback on the service. Residents had access to televisions, radio and newspapers. An activity schedule outlined activities available Monday to Sunday, however this schedule did not ensure that all residents had access to meaningful activities. This was reflected in the inspectors observations on the day of the inspection, in documentation and from residents' feedback. This is further discussed under Regulation 9: Residents' rights.

Where a resident had been temporarily transferred to hospital, a transfer letter was used to capture relevant detail, and inspectors were told that copies of current medicine prescriptions were also sent with the resident. Hospital discharge letters were also available for review, and the inspectors saw that the resident's GP reviewed this documentation upon the residents return to the designated centre. However, there was evidence that a resident was discharged in an unplanned and unsafe manner. This is discussed under Regulation 25: Temporary absence or discharge of residents.

Regulation 25: Temporary absence or discharge of residents

The provider had not ensured that the discharge process aligned to the regulations, this was evidenced by a resident who was discharged in an unplanned and unsafe manner. This discharge was not appropriately discussed with the resident in advance of the discharge. This process did not uphold the residents' rights or ensure a safe and effective discharge for the resident.

Judgment: Not compliant

Regulation 28: Fire precautions

A review of fire precautions in the centre found that the provider had completed the actions set out in the compliance plan submitted following the previous inspection. Fire doors were replaced with 60 minute doors and floor plans were posted on walls throughout the centre.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While in the sample reviewed, all residents had care plans in place that were reviewed at regular intervals, inspectors found that in a review of residents' records, there was gaps in meeting residents needs as per their comprehensive assessments. For example:

- Not all residents had comprehensive assessment completed prior to admission to ensure the care needs could be met. For example not all residents had access to appropriate equipment to meet their needs on admission.
- A resident's wound care plan evidenced that wound care should be provided every two days or more frequently if required. However, from a review of the resident's wound assessments, this was routinely being completed every three days which was not in line with the assessment. In addition, on two occasions these assessments were not completed for eight and then ten days.
- Nursing assessments identified two residents with a high risk of developing pressure ulcers, and it was reflected in their care plans they should be repositioned every two hours as a preventative measure. The repositioning charts for both residents reviewed had gaps of four-five hours on the

morning of the inspection, and one of these residents had a gap of 13 hours, the day prior to the inspection.
- A resident's nutrition care plan did not reflect advice from the dietitian in respect to their weight management plan. While the catering team were aware of the recommended dietary requirements and these were seen to be implemented for main meals, implementation was not consistent for all meals such as the mid-afternoon snack. On the day of the inspection, the resident was provided with a normal dessert and biscuits, which were not in accordance with the dietitians recommended low calorie diet.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors saw that one resident had been reviewed by a nurse specialist five weeks prior to the inspection where a recommendation was to make several referrals for additional professional expertise, these included occupational therapy, psychiatry of older age and the resident's GP. While inspectors were aware some referrals were in progress, for many of these recommendations, there was no evidence all recommended referrals had been followed up in a timely manner.

Additionally, not all residents received appropriate medical and health care following admission to the centre. This was evidenced by one resident who required professional expertise, was not referred for review in a timely manner.

Judgment: Substantially compliant

Regulation 8: Protection

While there were measures in place to protect residents from abuse, not all of these measures were seen to be sufficiently robust. For example:

- While there was evidence that an allegation of abuse had been actioned, all areas of the allegation were not seen to be appropriately investigated, and therefore, assurances were not provided that all sufficient controls were in place to safeguard residents.
- For three residents with known safeguarding needs, while they had safeguarding care plans developed, these were generic and referred to the overall safeguarding policy within the centre rather than outlining the specific safeguarding measures and actions required for each resident. This created a risk that staff would not have sufficient information on the specific measures in place to safeguard the individual residents. This risk was evident during the

inspection, when two staff spoken with were unaware of the safeguarding concerns relating to two of the three residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Not all residents had opportunities to participate in activities that reflected their individual interests and preferences. For example, the activity schedule identified three activities for each day, seven days a week, and therefore residents had access to 21 activities over the course of the week. However, inspectors saw that for the week of the inspection, 10 of the 21 scheduled activities were religious based .

The hairdresser visit was also identified as an activity. This limited the range of activities available to residents who did not wish to participate in religious activities or those who did not wish to have their hair done.

Inspectors also reviewed the activity provision for two residents who were nursed in bed, and found they had limited access to meaningful engagement. For example, one resident had one activity provided in July, such as enjoying ice-cream in their room from the visiting ice-cream van, a week prior to the inspection, and there were no activities documented for the month of June or May for this resident.

The only bath within the centre had the door locked and residents were required to ask a staff member should they wish to have access to the bathroom. Therefore, this bathroom was not freely accessible to residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sonas Nursing Home Tullow OSV-0005417

Inspection ID: MON-0050239

Date of inspection: 15/07/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Following the inspection, the training matrix was reviewed in full, and all outstanding mandatory training identified during the inspection was addressed. Staff identified as having outstanding fire safety and safeguarding training were scheduled for and completed the required training. Nursing staff identified as requiring refresher training in care planning also completed the relevant training. The training matrix has been updated and is now reviewed weekly by the Person in Charge and the Quality Manager. Mandatory training compliance rates are reported to the Clinical Governance Lead through the weekly report, providing ongoing oversight of compliance levels. Training expiry dates are monitored in advance to ensure that staff are identified and scheduled for refresher training within the required timeframes, thereby reducing the risk of training lapses. A section of compliance with mandatory training has also been incorporated as a standing agenda item at the homes monthly governance meeting, which is chaired by the Quality Manager and attended by the Clinical Governance Lead. This provides an additional level of governance & oversight, ensuring that any emerging gaps are identified and addressed promptly, and supports sustained compliance.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Following the inspection, the governance and management systems were reviewed to strengthened and address the areas identified by inspectors. The registered provider has recognised the need to ensure that every admission is preceded by a comprehensive assessment of the prospective residents needs and a corresponding assessment of the homes capacity to meet those needs safely and appropriately from the point of admission. Revised assessment documentation and staff guidance is now in place require both elements to be completed and documented, with complex or specialist admissions subject to review and approval by the Clinical Governance Lead prior to any admission decision being made. The discharge process has been comprehensively reviewed and strengthened to ensure that all discharges are planned, safe, appropriately documented and completed in consultation with the resident and, where appropriate, their representative. The registered provider will ensure that the discharge plan is documented and clearly records the actions required, responsible persons, relevant referrals and escalations, and proposed arrangements for transfer. The plan must be reviewed and updated at defined intervals until a safe and appropriate discharge has been completed. The residents and, where appropriate, their representative must be meaningfully consulted and kept informed throughout the discharge and transfer process. Each consultation, decision, escalation, referral and response from external agencies or services must be clearly documented, including the date, outcome and any agreed follow-up actions. Incident-management arrangements were reviewed. Post-incident documentation, including post-fall assessments, are now checked by the management team and signed off by the PIC to ensure that the relevant policy and clinical procedures have been followed. Incident trends and learning are reviewed through the homes governance meetings and quarterly triangulation of data. The registered provider will ensure that all statutory notifications are submitted to the Chief Inspector within the required regulatory timeframes. The oxygen cylinders identified during the inspection were reviewed and appropriate oxygen safety signage was put in place. Following the inspection, the concern regarding the accuracy of the residents chiropody record was reviewed by the Person in Charge. The residents foot care needs were reassessed, and appropriate follow-up was arranged to ensure that any identified discomfort or care needs were addressed promptly. A review of the relevant records was undertaken to establish whether the documented chiropody service had been provided and whether the record accurately reflected the care delivered. The importance of ensuring that all records are contemporaneous, accurate and reflective of the care and services provided has been reinforced with staff. Additional oversight has been introduced through regular auditing of residents care records. These audits include cross-checking documented appointments and interventions against the care provided and, where appropriate, the residents current condition and feedback. Any discrepancies identified through these audits are addressed promptly with the staff member concerned, and findings are reviewed by the Person in Charge and Quality Manager. Trends of concern or recurring issues are escalated through the homes governance arrangements to ensure appropriate corrective action is taken and to support	

ongoing compliance with accurate and reliable record-keeping requirements.

A review of the GP Service Level Agreement has taken place with the GP, and services are now meeting the agreed terms set out in the Service Level Agreement. Out- of hours services are being utilised when required. Any deviation from the SLA will be risk assessed and a robust review of the service will take place.

These areas are now monitored through the homes weekly report, operational plan and governance meetings, with identified actions assigned and tracked through to completion.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The contract of care identified during the inspection as outstanding was reviewed, and the required action was completed.
A comprehensive review of all residents contracts of care was subsequently undertaken to ensure that each contract was appropriately completed, signed and in place.
The Person in Charge is now required to report through the weekly report, any contracts of care that are awaiting signature or not yet in place. All outstanding contracts are monitored by the Quality Manager and tracked through to completion to ensure ongoing compliance and prevent recurrence.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Following the inspection, the notification process was comprehensively reviewed. The four notifications identified as having been submitted outside the required timeframe were addressed.
A review of notifiable incidents was completed to ensure that all notifications required under Schedule 4 had been appropriately submitted, including quarterly notifications and

follow-up information where applicable.
The Person in Charge and Quality Manager now reviews all incidents to determine whether they meet the criteria for notification to the Chief Inspector. Notification requirements and regulatory timeframes were also reviewed with the nursing management team.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints procedure displayed within the home was reviewed following the inspection and updated to correspond with the approved complaints policy and current regulatory requirements.
The revised complaints procedure has been displayed prominently in appropriate areas of the centre so that it is readily accessible to residents and visitors.
Residents were informed of the complaints process and their right to raise concerns through the homes residents meeting.

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
The discharge process has been comprehensively reviewed and strengthened to ensure that all discharges are planned, safe, appropriately documented and completed in consultation with the resident and, where appropriate, their representative. The registered provider will ensure that the discharge plan is documented and clearly records the actions required, responsible persons, relevant referrals and escalations, and proposed arrangements for transfer. Discharge plans are reviewed and updated at defined intervals until a safe and appropriate discharge has been completed.
All potential discharges or permanent transfers are discussed with the Quality Manager & Clinical Governance Lead at the monthly governance meeting to ensure compliance with the policy and that the residents rights are maintained.
Where there is any concern regarding whether a proposed discharge can be completed safely, the matter is escalated to the PIC and senior management before the discharge proceeds.
Discharges are now subject to management oversight to provide assurance that they are

appropriately discussed, planned, agreed, documented and safely completed.
Onsite training in residents rights and discharge planning is scheduled for 29.10.26.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Following the inspection, the assessment and care-planning arrangements were reviewed, with particular attention to the deficits identified regarding pre-admission assessments, wound care, repositioning and nutritional management.
The pre-admission assessment process has been strengthened to ensure that all health, personal and social care needs are comprehensively assessed and the homes capacity to meet those needs, including access to appropriate equipment is adequately considered prior to admission.
The care plans of residents identified during the inspection were reviewed and updated as appropriate to ensure that assessed needs and recommendations from healthcare professionals were accurately reflected.
Wound-care documentation and associated care plans were reviewed to ensure that wound assessment and dressing frequency corresponded with the residents prescribed care requirements.
Repositioning requirements for residents at risk of pressure injury were reviewed and clearly documented. Nursing staff now monitor repositioning records to ensure that prescribed interventions are carried out and that omissions are identified and addressed promptly.
Nutritional care plans have been reviewed to ensure that recommendations from dietitians are incorporated into the resident's care plan for all meals, snacks and refreshments and this has been communicated to nursing, care and catering staff.
Care plans will continue to be audited as part of the operational plan, with an enhanced focus on the effective implementation of identified care needs and interventions. The Person in Charge and home management team will monitor ongoing compliance through weekly KPI reviews, daily walkarounds, supervised practice, and resident feedback. Any gaps identified will be addressed promptly through appropriate corrective actions, with follow-up monitoring undertaken to ensure improvements are implemented and sustained.

Regulation 6: Health care	Substantially Compliant

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

Following the inspection, outstanding healthcare recommendations and referrals were reviewed and progressed as clinically appropriate.
A referral tracking system has been implemented to record recommendations and referrals to GPs and other health and social care professionals. The system records the date the recommendation was made, the professional or service required, the date the referral was submitted, follow-up actions and the outcome.
Nursing staff have been instructed to escalate delayed or outstanding referrals to the home management team to ensure timely follow-up.
Recommendations made by healthcare professionals are reviewed and incorporated into residents care plans, where appropriate, and monitored through to completion.
The referral tracker is reviewed by nursing management as part of the monthly clinical governance meeting to provide assurance that residents receive timely access to appropriate medical care and additional professional expertise.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Following the inspection, safeguarding arrangements were reviewed and strengthened. The safeguarding concerns identified during the inspection were reviewed to ensure that all relevant aspects had been appropriately considered and that appropriate safeguarding measures were in place.
Safeguarding care plans were reviewed and individualised to reflect each residents specific circumstances and identified risks. The revised plans clearly identify the safeguarding concern, preventative measures, actions required by staff, reporting and escalation arrangements, and ongoing monitoring requirements.
Relevant safeguarding information and individual protective measures were communicated to staff responsible for residents care, while maintaining appropriate confidentiality.
Staff awareness of individual safeguarding arrangements is reinforced through handovers, supervision, daily huddles and management oversight.
Outstanding safeguarding training identified during the inspection has been addressed as part of the homes mandatory training programme.
Safeguarding care plans are reviewed as part of the monthly governance meeting with the Quality Manager and Clinical Governance Lead to ensure they remain person-centred, responsive to each residents individual needs, and reflective of any identified safeguarding risks. These reviews also provide assurance that all agreed safeguarding

measures and interventions are being implemented effectively in practice. Any gaps or areas requiring improvement are identified, assigned for action, and followed up to ensure timely completion and sustained compliance.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Following the inspection, the homes activity programme was reviewed in consultation with the residents to ensure they have greater opportunities to participate in meaningful activities based on their individual interests, preferences and capacities. The weekly activity programme was revised to provide a broader and more varied range of activities. Religious activities continue to be available for residents who wish to participate, while alternative activities and choices are provided for residents who do not wish to participate. Feedback received from residents regarding outings, live music and opportunities for increased social engagement was incorporated into the review of activity provision. The activity needs of residents who remain in their bedrooms were individually reviewed. Individualised one-to-one activities and meaningful engagement are now provided according to each resident's interests and abilities, with engagement appropriately documented. The practice of restricting general access to the assisted bathroom was addressed and the bathroom is now accessible to all residents. Activity participation and meaningful engagement are monitored by the activity team and nursing management. Particular attention is given to residents who spend significant periods in their bedrooms to ensure they are not socially isolated and have meaningful opportunities for engagement. Residents feedback continues to be sought through resident meetings and individual consultation, and the activity programme is adjusted in response to residents' preferences.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	25/09/2026
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.	Substantially Compliant	Yellow	25/09/2026
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the	Substantially Compliant	Yellow	25/09/2026

	number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 25(4)	A discharge shall be discussed, planned for and agreed with a resident and, where appropriate, with their family, and in accordance with the terms and conditions of the contract agreed in accordance with Regulation 24.	Not Compliant	Orange	29/10/2026
Regulation 25(3)	The person in charge shall ensure that, in so far as practicable, a resident is discharged from the designated centre concerned in a planned and safe manner.	Not Compliant	Orange	29/10/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	25/09/2026
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation	Not Compliant	Orange	25/09/2026

	to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.			
Regulation 31(2)	The person in charge shall ensure that, when the cause of an unexpected death has been established, the Chief Inspector is informed of that cause in writing.	Not Compliant	Orange	25/09/2026
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	25/09/2026
Regulation 34(2)(g)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as appropriate, in the	Substantially Compliant	Yellow	25/09/2026

	event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.			
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).	Substantially Compliant	Yellow	25/09/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social 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.	Substantially Compliant	Yellow	25/09/2026
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	Substantially Compliant	Yellow	25/09/2026

	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)(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.	Substantially Compliant	Yellow	25/09/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	18/09/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	25/09/2026
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	Substantially Compliant	Yellow	25/09/2026

	not interfere with the rights of other residents.			