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:	St. Gobnaits Nursing Home
Name of provider:	St. Gobnaits Nursing Home Limited
Address of centre:	Drewscourt, Ballyagran, Killmallock, Limerick
Type of inspection:	Unannounced
Date of inspection:	20 April 2026
Centre ID:	OSV-0005668
Fieldwork ID:	MON-0050283

About the designated centre

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

St. Gobnait's in Ballyagran, Limerick provides 24-hour nursing care, primarily for male and female residents over the age of 65 years. Up to 20 residents can be accommodated in the centre, for long-term residential care or respite care. Residents ranging from low-level dependency to max-level dependency are catered for, as well as persons with intellectual, physical and sensory disabilities and those with varying levels of dementia who require nursing care. The accommodation consists of ten single rooms and five twin rooms. There are three bath/ shower rooms. Admissions to St. Gobnait's are arranged following a pre-admission needs assessment. A holistic approach is taken to residents' care. Residents care plans are person-centred and are reviewed on a 3 monthly basis. Services and activities available to residents are: a hairdresser, chiropody, physiotherapy, speech and language therapy, arts and crafts, a sensory garden, etc. Residents are continually consulted with regarding the operation of the Home. St. Gobnait's operate an open visiting policy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 20 April 2026	09:50hrs to 18:15hrs	Sean Ryan	Lead
Monday 20 April 2026	09:50hrs to 18:15hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

Residents living in St. Gobnaits Nursing Home described a good quality of life and reported that they were treated with respect and dignity by staff. Residents stated that they knew staff well and found them attentive to their needs. This familiarity contributed to residents feeling comfortable and at home within the centre.

This was an unannounced inspection carried out by an inspector of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also followed up on the action taken by the provider to address issues identified during the previous inspection of the centre in April 2025. In addition, inspectors reviewed unsolicited information received by the office of the Chief Inspector.

Inspectors arrived unannounced at the centre and were met by the senior nurse on duty and the person in charge. A brief introductory discussion took place to gather information regarding residents living in the centre. Inspectors then undertook a walk-through of the premises, observing staff and resident interactions, the care environment, and spent time speaking with residents.

Inspectors observed a calm and relaxed atmosphere throughout the centre. At the time of inspection, a number of residents had finished breakfast and were in the day room watching the news. A staff member was present in this area, engaging with residents on a one-to-one basis and facilitating both individual and group activities. Some residents were being assisted with their morning routines. Staff were observed supporting residents to walk along corridors and engaging them in friendly conversation about the weather and local events. These interactions were seen to be warm and person-centred.

Inspectors met with residents in the communal areas of the centre and also spoke with residents in the privacy of their bedrooms. All residents were met with during the course of the inspection, and a number of residents spoke in more detail about their experience of living in the centre. Overall, residents expressed high levels of satisfaction with the service provided and described the centre as a homely and comfortable place to live. Residents consistently described staff as kind, caring and attentive, and said they were familiar with staff members, which contributed to them feeling at ease and well-supported.

Residents reported that they were supported to make choices about their daily routines, including the time they got up in the morning and when they wished to have a shower. Residents confirmed that they were treated with dignity and respect in their day-to-day lives. They spoke positively about spending time in the day room, where there was usually a variety of activities taking place, and where they also enjoyed sitting, chatting with staff, watching television, and socialising with other

residents. Residents described the food as very good, noting there was always plenty available.

Inspectors observed the residents' dining experience and found this to be a calm, unhurried and social occasion. The majority of residents attended the dining room, and they were offered choice in relation to their meals. Staff were attentive and responsive to residents' needs, ensuring that condiments were readily available. Where residents required assistance, this was provided in a discreet and sensitive manner that respected the residents' dignity and independence.

Inspectors observed that residents who required therapeutic or modified consistency diets were appropriately catered for, and meals were presented in line with their assessed needs. Residents were not rushed and were supported to enjoy their meals at their own pace. Two residents described the food as "beautiful" and, when asked if they had enjoyed their meal, gestured towards their empty plates to indicate satisfaction. Residents also confirmed that additional portions were available, if requested.

The centre was bright, colourfully decorated, and designed to promote a homely environment. Photographs and artwork were displayed throughout the centre and along corridors. A large notice board displayed photographs of staff on duty, which supported residents in identifying staff members. Information boards were also available, providing details about the centre, services available, the complaints processes, and access to independent advocacy and safeguarding supports. However, inspectors observed that some of this information was not accurate or up-to-date, particularly in relation to personnel responsible for managing complaints.

Inspectors observed that residents' bedroom accommodation was generally clean and well-maintained. However, some areas of the premises were not cleaned to an appropriate standard, including storage areas, sluice facilities, and communal shower facilities. In addition, some areas were noted to be in a poor state of repair, including damaged floor coverings and issues with fixtures such as bathroom locks.

Inspectors observed a number of fire safety risks in the centre. Deficits were observed in relation to a number of fire doors which had the potential to impact on the containment of fire and smoke in the event of an emergency.

While residents expressed general satisfaction with their bedroom accommodation and storage, inspectors found that some shared bedrooms were not configured in a way that ensured equitable space or access to personal belongings. In some instances, the layout of rooms did not allow for adequate furniture, such as seating for residents. Inspectors also observed that the premises was not suitable to meet the assessed needs of all residents, particularly those with complex mobility and transfer requirements. The layout, space and accessibility within the centre did not support safe movement or promote the independence and dignity of a resident with additional and complex mobility needs.

Inspectors observed that most residents chose to spend their day in the day room, which was supervised by a staff member throughout the day. This area was active and engaging, with a range of activities taking place, including conversations, music,

and manicures. Residents spoke positively about this space and told inspectors that they enjoyed spending time there and valued the opportunity to socialise and interact with others. On the day of inspection, the weather was warm, and some residents chose to spend time outdoors, as was their usual preference. Residents were observed sitting outside and enjoying the fresh air, while others were seen in the garden area with visitors. This contributed to a relaxed and pleasant atmosphere within the centre.

The following sections of this report detail the findings with regard to the capacity and capability of the provider, and how this supports the quality and safety of the service provided to residents.

Capacity and capability

The findings of this inspection were that while residents reported a good quality of life in the centre, the oversight of the service was not fully effective to ensure compliance with the regulations, and a deterioration in regulatory compliance was identified since the previous inspection in April 2025. Inspectors found that a poorly defined organisational structure, with unclear lines of authority and accountability, impacted on the effective oversight of the service provided to residents. The provider had not ensured that appropriate management systems were in place to monitor the quality of all care provided to residents, or to effectively identify, assess and manage risks that may impact on the safety and welfare of residents, particularly in relation to fire safety. As a consequence of these findings of concern, an urgent compliance plan was issued to the provider following this inspection.

Inspectors reviewed unsolicited information received by the Chief Inspector. The information received pertained to concerns regarding the governance and management of the centre, the quality of care provided to residents including health care and wound care, and the management of complaints. This information was found to be fully substantiated on this inspection.

St. Gobnaits Nursing Home Limited is the registered provider of St. Gobnaits Nursing Home. It is a company consisting of two directors. A director of the company represented the provider in engagement with the Chief Inspector and also held the role of person in charge. They were responsible for the governance, clinical oversight, and operational management of the service. A senior nurse supported the person in charge in the administration of the service.

While the centre had a nurse management structure in place, the roles, responsibilities and lines of accountability within this structure were not clearly defined. The management arrangements in place did not clearly allocate responsibility for the clinical oversight and monitoring of key aspects of the service. Consequently, it was not clear who held responsibility for the oversight of systems such as records management, nursing documentation and care planning, risk

management, complaints, and the monitoring of residents' health care needs. This lack of oversight meant that some risks within the service were not identified through the centre's monitoring arrangements. For example, inspectors were informed that no residents had pressure-related injuries. However, this was not consistent with findings on inspection, where two residents were identified as having pressure-related wounds. As a result, a request for immediate action was issued to the provider, requiring a fulsome assessment of all residents' skin integrity to ensure accurate identification, documentation and care of wounds.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. While the provider had a system of audits to evaluate clinical and environmental aspects of the service, the audit findings reviewed by inspectors did not identify issues of known risk in the centre. For example, a review of fire safety audits completed in April 2026 indicated compliance with key measures such as the appointment of fire wardens on each shift, the condition of fire doors, and the accessibility of escape routes. However, inspectors found that staff designated as fire wardens had not received appropriate training, escape routes were obstructed, and some fire doors were impaired.

The system in place to manage risk was not fully effective. Known risks, in relation to the care of some residents, including those with complex care and mobility needs were not consistently identified, documented, appropriately managed, or effectively reviewed. For example, while the provider was aware that staffing resources were insufficient to meet the assessed needs of a resident, there had been no assessment of the risks and no appropriate action taken to mitigate the risk, which impacted on the quality and safety of care being provided. In addition, there was inadequate documentation of adverse incidents, including falls, which were not fully investigated or analysed, and no quality improvement actions were implemented to reduce the risk of recurrence.

The provider had not ensured that staffing resources were effectively organised and managed in the centre to ensure that care was provided to residents, in accordance with their assessed needs. While residents needs had been assessed and specific staffing levels identified, a review of rosters indicated that these staff levels were not implemented. As a result, there was insufficient staff on duty to meet the assessed needs of some residents, and where staff were directed to support higher-dependency residents, this direction impacted negatively on the care provision for others.

While there had been some action taken in the management of records since the previous inspection, particularly in terms of their availability and accessibility, the provider had not fully complied with the requirements of Regulation 21, Records. For example, the directory of residents did not contain all the information required under Schedule 3 of the regulations, and records relating to the nursing care and treatment provided to residents was incomplete.

The management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner. Inspectors identified information consistent with complaints in

relation to care delivery and staff interactions. While this information had been brought to the attention of the management, the complaints were not appropriately documented or managed within the complaints register, in line with the centre's own complaints management policy. In addition, the complaints procedure displayed within the centre was not updated to accurately reflect the personnel responsible for the management of complaints.

A programme of training was in place for staff, which included areas such as fire safety, safeguarding and supporting residents living with dementia. However, a number of staff had not completed training or were not appropriately trained for the roles they were undertaking.

Inspectors found that staff were not adequately supervised to ensure residents' care needs were met in accordance with their individual care plans. For example, the oversight of wound care did not ensure that care was delivered and documented in line with professional guidelines. Furthermore, there was a lack of supervision in relation to the quality and accuracy of records maintained by staff.

Regulation 15: Staffing

Staffing levels were not adequate to meet the assessed care and supervision needs of residents at all times. Inspectors identified that, particularly in the afternoon and at night-time, there were insufficient staff available to attend to residents' care needs, including ensuring residents' safety and the safe and timely evacuation of residents in the event of an emergency.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately trained to deliver effective and safe care to residents. This was evidenced by;

- A significant number of staff had not completed fire safety training or had training that had expired. Staff provided inconsistent responses in relation to fire management and evacuation procedures within the centre.
- Some staff had not completed, or had expired training in patient moving and handling, despite being required to provide care and support to residents with complex mobility and transfer needs.
- Some staff had not completed, or had expired, training in the delivery of emergency life-saving interventions, in line with some residents' care plans.

Staff were not always appropriately supervised. For example;

- Staff were not appropriately supervised to ensure that pressure care management interventions were consistently implemented, and records maintained to provide assurance that these interventions were carried out as required.
- There was poor supervision of resident's clinical documentation to ensure that resident's assessments and care plans were an accurate reflection of the residents care needs. In addition, nursing care records were not appropriately maintained to reflect the care provided to residents on a daily basis.
- Arrangements were not sufficiently robust to ensure that all staff received appropriate levels of supervision and support, including when enhanced oversight was required.

Judgment: Not compliant

Regulation 21: Records

A review of the record management systems in the centre found that records were not managed in line with regulatory requirements. For example;

- The nursing record for one resident's care received following an incident in which a resident suffered harm was poorly documented and investigated. There was no documented assurance that appropriate assessment, treatment and care was delivered to a resident following a fall.
- Records of specialist treatment and nursing care provided to residents were not maintained in line with the requirements of Schedule 3(4)(b). For example, records of wound care for residents at high risk of impaired skin integrity were poorly maintained.
- The director of residents was not maintained in line with the requirements of Schedule 3 of the regulations. Details of resident transfers from the centre, including the date of transfer and the location to which residents were transferred, were not recorded.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured that resources in the centre were planned and managed to ensure person-centred, effective and safe services. In particular, there was a failure to appropriately plan and organise staffing, resulting in insufficient numbers of staff on duty to meet the assessed needs of all residents.

The registered provider had not ensured there was an effective management structure in place, with clear lines of accountability and responsibility. In particular,

there was a lack of defined responsibility for key aspects of the service, including the oversight and management of staffing resources, risk management, and the monitoring of care provided to residents. Consequently, a known risk was not effectively reviewed or managed, resulting in a deterioration in aspects of the service.

The management systems in place to monitor the quality of the service were ineffective to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- Risk management systems were not effectively monitored or implemented. The provider did not adequately record known risks within the centre, including those associated with staffing constraints. Furthermore, risks were not appropriately identified or assessed, particularly in relation to fire safety.
- Systems in place for the oversight and monitoring of residents' health care needs, particularly in relation to wound care and skin integrity, were not effective. As a result, an immediate action was issued requiring review of all residents skin integrity. This action was completed, and assurance was provided that this aspect of care was appropriately managed.
- There was poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to nursing documentation.
- The systems in place to monitor, evaluate, and improve the quality of the service were not effective in identifying deficits and risks in the service. For example, completed audits with regard to the physical environment, records, fire safety and restrictive practices reflected full compliance and did not identified aspects of the service that were not in full compliance with the regulations or required quality improvement.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had not been updated to reflect changes to the organisational structure of the designated centre or the current arrangements in place for the management of complaints.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

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

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were not recorded and managed in line with the centre's own policy and the requirements of the regulation.

Not all complaints or expressions of dissatisfaction with the service had been appropriately documented and investigated, and therefore, there was no plan in place to address the issues of concern. In addition, inspectors were informed by nurse management that complaints had been received in relation to aspects of the quality of the service. However, there was no record of these complaints being documented.

Judgment: Not compliant

Quality and safety

Inspectors found that residents generally appeared comfortable in the centre and residents expressed satisfaction with aspects of the care and support provided to them. However, inspectors found, as described in the capacity and capability section of this report, that monitoring arrangements within the centre were not consistently effective, which impacted on the quality and safety of care in a number of areas including the provision of health care and fire safety. In addition, the assessment of residents needs was not always effective in comprehensively identifying residents' care needs or ensuring that appropriate supports were in place.

Inspectors reviewed residents' assessments and care plans and found that, although all residents had a care plan in place, these plans were not always based on a comprehensive assessment of their care needs or reflective of their actual care needs. In addition, pre-admission assessments were found to be incomplete and did not adequately identify residents care needs or the supports, interventions and resources necessary to meet those needs safely or effectively. As a result, some residents' mobility, social care and personal care needs were not consistently met and this impacted on their overall quality of life in the centre.

Most residents had access to a medical practitioner of their choice, some did not. In those cases, residents were not seen by a medical practitioner for a significant

period of time. Arrangements were not consistently in place to ensure residents had timely access to appropriate health care professionals for further expert assessment, including tissue viability nursing expertise, when clinically indicated.

Residents were provided with access to adequate quantities of food and drinks, and meals were prepared, cooked and served in the centre. Inspectors found that residents were offered choice at mealtimes and the food provided was wholesome and nutritious.

Inspectors reviewed the arrangements in place in relation to fire safety. Regular fire safety checks in the centre were completed and recorded. There were daily, weekly and monthly checklists which included testing of fire equipment, fire alarm testing, emergency lighting, means of escape and fire exit doors, all of which were up-to-date. However, this inspection identified a number of deficits in some fire doors which could impact containment of fire within the premises. Significant gaps were observed between the bottom of some fire doors and the floor, and penetrations through walls and ceilings were visible, and may not have been adequately sealed. This could potentially impact on fire containment measures in the event of a fire. In addition, residents personal emergency evacuation plans did not accurately reflect their assessed evacuation needs. This, combined with deficits in staff knowledge in relation to fire safety and evacuation procedures, posed a significant risk to the safe and timely evacuation of residents, particularly those with complex care and mobility needs. An urgent compliance plan was issued to the provider following the inspection. The response provided assurance that these risks had been addressed.

The premises was bright and decorated in a manner that promoted a homely environment for residents. However, inspectors found that storage arrangements were not adequate and there was poor management of storage observed, particularly in the designated store rooms and sluice facilities. In addition, the configuration of some shared bedrooms did not ensure that all residents had equal access to storage for their personal possessions. While the centre was generally well-maintained, issues were identified in relation to cleanliness, and some areas were noted to be poorly ventilated at the time of inspection.

Regulation 11: Visits

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

Judgment: Compliant

Regulation 17: Premises

There were aspects of the premises that did not fully comply with the requirements of Schedule 6 of the regulations.

- Floor coverings in some areas were not appropriately maintained. For example, the floor covering was damaged in communal bathrooms. Floor coverings were lifting away from skirting in a number of bedrooms. Skirting was also visibly damaged in residents bedrooms. This resulted in a build up of dirt and debris.
- Storage facilities were inadequate and resulted in the inappropriate storage of residents' equipment in bedrooms. For example, mobility aids and hoists were stored in a number of resident bedrooms.
- In four shared bedrooms, the configuration and layout of the bedrooms did not support residents in having equitable personal space, unrestricted access to their storage, or adequate seating.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents had access to adequate quantities of food and drink, including a safe supply of drinking water. A varied menu was available daily, providing a range of choices to all residents including those on a modified consistency diet.

Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required. There was evidence that the recommendations made by those professionals were implemented and reviewed which resulted in good outcomes for residents.

There were sufficient numbers of staff to provide residents with assistance at mealtimes.

Judgment: Compliant

Regulation 28: Fire precautions

Following this inspection, the provider was required to submit an urgent compliance plan to address an urgent risk in relation to the safety of residents. These risks related to the effectiveness of fire safety arrangements, including the adequacy of staffing levels to support timely evacuation, the assessment of residents' evacuation and dependency needs, the implementation and oversight of staff training in fire safety, emergency procedures and fire drills. The provider's response provided assurance that the risks had been addressed.

The provider did not have adequate precautions against the risk of fire in place. For example;

- Records indicated that weekly fire door checks were being undertaken. However, these checks consistently recorded no defects, despite management being aware of certain fire doors that were damaged and potentially compromised. Consequently, fire safety checks were not being effectively implemented to ensure fire risks were appropriately identified and managed.

Arrangements for the containment of fire was inadequate. For example;

- A number of fire doors were observed to be in a damaged condition. Deficits included excessive gaps, visible damage, and the absence or deterioration of required smoke seals. As a result, the integrity and effectiveness of these doors in event of a fire could be impaired.
- Other fire doors did not appear to meet the criteria of a fire door as they had domestic type locks and handles, screws missing from hinges and the hinge was not fire-rated.
- Services such as pipe-work and cabling, were observed passing through walls and ceilings without evidence of appropriate fire stopping.

While fire drills had been completed in the centre, no fire drill had been carried out to simulate the evacuation of residents with complex care, mobility and evacuation needs. Staff confirmed that they had not participated in any such drill and were unsure how to safely evacuate the residents from the building in the event of a fire. In addition, there was uncertainty regarding the use of evacuation equipment, including whether it could be effectively maneuvered through door widths within the centre. This lack of staff preparedness presented a significant risk in relation to the safe and timely evacuation of residents.

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;

- Pre-admission assessment were incomplete and failed to identify a residents complex care needs and the associated equipment and staff resources necessary to safely meet their needs. This resulted in the necessary supportive equipment not being available to a resident. Some equipment necessary to monitor their complex care needs was not in place of the day of inspection.
- Care plans were not guided by a comprehensive assessment of the residents care needs. Some residents' care plans did not accurately reflect the needs of

the residents and did not identify interventions in place to support residents at high risk of impaired skin integrity and developing pressure related injuries to their skin. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of some residents who had experienced a fall had not been reviewed or updated following a change in their mobility care needs. Consequently, their care plan did not reflect the nursing interventions required to support their needs.

Judgment: Not compliant

Regulation 6: Health care

Residents were not always provided with appropriate medical and health care including a high standard of evidenced-based nursing care, in accordance with professional guidance.

- Some residents were not provided with timely access to general practitioner services when clinically indicated. For example, one residents had not been reviewed by a general practitioner in a period of six months despite showing signs of physical deterioration.
- Appropriate arrangements were not in place to ensure the timely identification, assessment and management of risks associated with impaired skin integrity. Residents at risk of pressure related skin injuries were not consistently assessed or monitored. Furthermore, where residents had been reviewed by health care professionals, it was not always evident that recommendations were implemented in practice.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant

Compliance Plan for St. Gobnaits Nursing Home OSV-0005668

Inspection ID: MON-0050283

Date of inspection: 20/04/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered Provider has conducted a comprehensive review of the current staffing levels and skill mix, having regard to the assessed care needs of all residents currently in the centre. One care assistant has been hired and is awaiting Garda vetting. A staffing plan has been developed and shall be reviewed at a minimum annually. To ensure enough appropriately skilled staff are always on duty, including during afternoon and nighttime shift. The plan will include residents' dependency assessments to ensure individuals care needs can be consistently met Where additional staffing resources are required, the provider will engage an agency or undertake recruitment to ensure safe staffing levels are maintained. Rosters will be reviewed by the person in charge on a weekly basis to confirm compliance with the agreed staffing schedule. The staffing levels will be documented in the centres risk register and monitored through the governance review process	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge has undertaken a full audit of all staff training records to identify staff who have not completed mandatory training or whose training has expired. The	

training matrix has been updated accordingly. All staff are expected to have completed their mandatory training by 30/06/26

A supervision framework will be introduced to provide structured, documented supervision for all nursing and care staff. This will include clinical supervision for nursing staff relating to wound care assessment. Documentation, and care plan review.

An external trainer has been engaged to provide wound care training to nursing staff in house on 9th June 2026.

An external trainer has been engaged to provide dementia care training in house on 10th June 2026.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The person in Charge has reviewed and updated the directory of residents to ensure it contains all information required under Schedule 3 of the regulations, including details of resident transfers, date of transfer, and date of admission.

A nursing documentation audit by the Person in Charge is in progress and shall identify gaps in clinical records, including records relating to specialist treatment, wound care, and nursing care provided following incidents such as falls. Education will be provided to nursing staff to ensure adequate improvements in relation to care plan documentation.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider will review and revise the management structure of the centre to clearly define roles, responsibilities and lines of accountability for all areas of care provision. An updated organisational chart will be prepared and included in the Statement of purpose.

Designated responsibility will be assigned in writing for the oversight of, staffing, risk

management, complaints management, nursing documentation and care planning, and resident health care monitoring. Job descriptions will be updated to reflect these responsibilities where required. The Person in Charge will retain overall insight.

The risk register will be reviewed and updated to ensure all known risks are documented, assessed, and that mitigation measures are in place.

The internal audit programme and audit tools have been reviewed by the Person in Charge. Audits findings ang quality improvement actions shall be reviewed regularly to support ongoing monitoring of the quality and safety of care provided to residents. Risks identified within the service shall be discussed with the management team and appropriate actions implemented to reduce identified risks.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The statement of Purpose has been reviewed and updated to accurately reflect the current organisational structure, management arrangements, and the name of the Complaints Officer

The Person in Charge will ensure annual review of the Statement of Purpose a minimum

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A full review of the complaints register was undertaken immediately to identify any complaints of expressions of dissatisfaction that had not been appropriately recorded, investigated, or responded to. Where gaps were identified, these were retrospectively documented and followed up with the relevant residents of their representatives.

The complaints information displayed within the centre have been updated to accurately reflect the names and roles of the personnel responsible for managing complaints at each state of the process.

St Gobnaits Nursing Home shall ensure that all complaints are managed and responded to in line with the complaints Policy and Procedure.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A schedule of works was prepared and prioritised to address the areas for improvement identified. A contractor has been engaged and works have commenced.

The storage requirements within the centre shall be reviewed to identified appropriate storage solutions for mobility aids and hoists that are currently stored in resident's bedrooms

The layout of the four identified shared bedrooms shall be reviewed with a view to reconfiguring these rooms where appropriate to ensure all residents have equal personal space, unrestricted access to their belongings, and adequate seating.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Fire engineers have been engaged to complete a comprehensive Fire Safety Risk Assessment on the 8th of June 2026. This shall include a review of pipe work and cabling passing through walls and ceilings to identify those requiring fire-stopping. Specialist works will be carried out and certified by an external service provider.

A comprehensive Fire Door Audit shall be completed by the fire engineers. Each door in the building shall be inspected by an external specialist. An action plan will be developed and associated improvement works shall be commenced in a timely manner. Specialist works will be carried out and certified by an external service provider.

A full simulated evacuation has been completed as part of the fire drill programme with an external specialist.

Fire drill will be conducted at regular intervals, including drills simulating the evacuation of residents with complex dependency and mobility needs. Records of all drills, including outcomes, learning points, and follow ups actions, will be maintained.

All PEEPs have been reviewed and updated by the Person in Charge
Weekly fire safety checks within the centre have been reviewed to ensure fire and risks are appropriately identified, escalated and addressed in a timely manner. Fire checking processes have been strengthened and enhanced oversight arrangements are now in place to ensure identified defects are appropriately documented, actioned and monitored to completion.
All staff have completed the fire safety training. Person in Charge will maintain the training matrix and review it regularly to ensure refresher training is completed within the required timeframes

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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:
A nurses meeting has been convened to address the non-compliances identified in this report, with particular emphasis on the completion of comprehensive assessments and the formulation of person-centred care plans based on assessed need.

The admission assessment process has reviewed to ensure the service care appropriately assess whether the centre can safely and effectively meet residents assessed needs prior to their admission.

A full audit of all current residents' care plans is being completed. Care plans identified as incomplete or not reflective of residents' current needs shall be updated, including care plans for residents who experienced a fall or a change in mobility needs. All residents have received a skin integrity assessment, and wound care plans have been updated in line with tissue viability nursing input.

Care plan audits are now completed regularly and are linked to the nursing supervision process. Clinical nurse supervision is carried out by the Person in Charge for nursing staff, and by charge nurse for care staff. Four monthly care plan reviews are scheduled for all residents, with compliance monitored through audit and reported at governance meetings.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
GP arrangements have been reviewed by the Person in Charge, and all residents have access to their chosen GP.

A GP review schedule is in place to ensure regular medical oversight of all residents and escalation of clinical concerns and requesting urgent medical review where indicated.

The Person in Charge maintains oversight of GP access, referrals to healthcare professionals and implementation of recommendations arising from medical and specialist reviews. Clinical audits and supervision processes are in place to monitor compliance with these arrangements.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/09/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	30/09/2026

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/09/2026
Regulation 23(1)(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.	Substantially Compliant	Yellow	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,	Not Compliant	Orange	24/04/2026

	appropriate, consistent and effectively monitored.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	08/06/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	30/09/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	24/04/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire	Not Compliant	Orange	12/05/2026

	fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	24/04/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	12/05/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	12/05/2026
Regulation 03(2)	The registered provider shall review and revise the statement of	Substantially Compliant	Yellow	30/06/2026

	purpose at intervals of not less than one year.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	30/09/2026
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.	Not Compliant	Orange	30/09/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in	Not Compliant	Orange	30/09/2026

	paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
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(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Substantially Compliant	Yellow	30/09/2026
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	30/09/2026