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:	Newbrook Nursing Home
Name of provider:	Newbrook Nursing Home Unlimited Company
Address of centre:	Ballymahon Road, Mullingar, Westmeath
Type of inspection:	Unannounced
Date of inspection:	12 February 2026
Centre ID:	OSV-0005702
Fieldwork ID:	MON-0046741

About the designated centre

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

Newbrook Nursing Home is registered to accommodate 119 residents. It consists of two separate buildings, a single storey and a two story building known as Newbrook 1 and Newbrook Lodge respectively. It is located in a residential area, within a few minutes drive from the town of Mullingar. Both buildings are surrounded by spacious landscaped gardens and there are secure courtyard garden spaces attached to each building that residents can use safely. One of the courtyards was set out in a traditional shopping streetscape design to provide interest for residents. Residents are accommodated in single and double rooms.

The centre provides care to residents over the age of 18 who have care needs related to aging, dementia, intellectual disability, physical disability and acquired brain injury. Care is provided on a long and short term basis and residents who require periods of convalescence, palliative care or rehabilitation are accommodated.

The aims of the centre as described in the statement of purpose is to provide a high standard of evidenced based care and to ensure that residents live in a comfortable, clean and safe environment that they can consider a "home away from home".

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	112

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
Thursday 12 February 2026	07:15hrs to 17:15hrs	Catherine Connolly-Gargan	Lead
Thursday 12 February 2026	07:20hrs to 17:15hrs	Sandra Rowland	Support
Thursday 12 February 2026	07:15hrs to 17:15hrs	Helena Budzicz	Support

What residents told us and what inspectors observed

Overall, this inspection found that there were contrasting standards of residents' nursing and social care between the two buildings known as 'Newbrook One' and 'The Lodge' that comprise this designated centre. The inspectors spent time speaking with many of the residents' and staff and observing staff practices and the care of residents throughout the day to gain insight into the residents' experiences of living in the centre. While many of the residents who lived in the Lodge building expressed their satisfaction with their care and the quality of their lives, the feedback from residents living in the Newbrook One building was that they were not satisfied with the opportunities they had to participate in meaningful social activities that interested them. This feedback from residents concurred with inspectors' observations of the residents' lived experiences during the day.

This was an unannounced inspection carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and to follow up on information of concern that had been received by the Chief Inspector since the last inspection in February 2025. The inspectors found that the information received was partially substantiated on this inspection, and the findings are discussed further under the relevant regulations in this report.

On arrival at 7:15am, the inspectors were met with a staff nurse working on night duty. Following introductions, the inspectors completed a walk around the centre. The inspectors observed that most of the residents were in bed sleeping, and a small number of residents were already awake resting in bed or sitting in a chair by their beds. Three of these residents told the inspectors that they liked to get up early. One resident told the inspectors that he was a farmer prior to coming to live in the centre and "getting up and going early in the morning was in his DNA". The staff working on night-duty were observed to be attentive to residents' needs and were kind, patient and caring in their interactions with residents as they assisted and cared for them.

Newbrook Nursing Home is located on the perimeter of Mullingar. The premises are purpose-built and are arranged in two separate buildings. Each building has a variety of single and twin-occupancy bedroom accommodation, communal rooms and safe outdoor areas for residents, including one outdoor area decorated in a traditional shopping streetscape style. The inspectors observed that the outdoor gardens and courtyards were well-maintained and were landscaped with flowerbeds, shrubs and small trees. The outdoor areas for residents' use had suitable outdoor seating. However, residents with health conditions affecting their cognition and dexterity who lived in the Lodge Unit could not independently access the outdoor area as they wished.

The residents' environment was observed to be warm and clean throughout. The communal areas were nicely decorated and furnished with comfortable seating for the residents' use. Residents' own and other artwork was framed and displayed along the corridor walls. The inspectors observed that a variety of other ornaments and traditional memorabilia made the residents' lived environment homely and familiar to them. Many of the residents' bedrooms were personalised with their family photographs and personal belongings, including their artwork, ornaments and soft furnishings. Some residents chose to bring small items of their favourite furniture from their homes in the community for their continued use in their bedrooms and this was facilitated.

A variety of communal sitting rooms and dining areas were provided in both buildings for residents' use. The communal rooms were conveniently located and decorated with traditional memorabilia that was familiar to the residents to support their comfort. A local priest celebrated Mass for the residents in the centre each week. A large church was located in Newbrook One, and an oratory was available in the Lodge buildings. Residents told the inspectors that they liked to visit the church or the oratory each day.

With the exception of one sitting room in Newbrook One building, where the inspectors observed there was insufficient supervision of residents with assessed high dependency needs and at risk of falling, staff remained with residents in the communal rooms at all times. This ensured that a staff member was available to respond to residents' needs for assistance without delay. While the inspectors observed that staff interactions with residents were kind and caring, residents' call-bells were ringing in both buildings for long periods of time throughout the day. On a number of occasions, inspectors had to alert staff to residents' requests for their assistance. Residents told the inspectors that they often had to wait for staff to come to assist them, and one resident asked an inspector to check if their call-bell was working.

Although a schedule was available of the social activities that were planned for each day, the inspectors observed that the opportunities for residents to participate in meaningful social activities were limited on the day of the inspection in Newbrook One building. The inspectors also observed that supervision and allocation of staff were not always adequate to ensure that many of the residents had adequate opportunities to participate in group and one-to-one social activities in the Newbrook One building as they wished. This observation was in direct contrast to the opportunities provided for residents in The Lodge building, where residents' social activities were led by a member of staff, and residents were observed to be engaged and mostly participating in the activities taking place. This observation concurred with the feedback received from residents in The Lodge building, who told the inspectors that they enjoyed the varied social activity programme available to them. This positive feedback was in contrast to the feedback from residents in Newbrook One who spoke with the inspectors. This was also evident in the contrasting atmospheres in the two buildings. Two residents in the Newbrook One building said that their day felt long at times. Another resident told the inspectors that they passed their day 'waiting on the family to come in' to visit them. Other

residents reported that the social activities taking place did not interest them or said that they were not aware there was any social activities available to them.

The inspectors observed the residents' mealtimes in Newbrook One building. While a small number of residents were assisted with eating their meals in the sitting rooms, most of the residents ate their meals in the two dining rooms, which were conveniently located on either side of the main kitchen. The inspectors observed that residents' meals were plated in the kitchen and served to them without discussion with them regarding the menu choices available, and while the inspectors saw that staff assisted residents as needed, three residents were not provided with food prepared as recommended by a Speech and language therapist (SALT), further to their assessment of these residents' needs. Inspectors also observed that not all staff involved in preparing modified food and fluids for individual residents, and in assisting them with eating and drinking, were appropriately supervised or qualified. As this practice posed a potential risk to residents' safety, inspectors immediately discussed this with the person in charge.

Residents told the inspectors that their visitors were always made welcome and that they could meet with them as they wished.

Residents told the inspectors that they felt safe in the centre and that they would speak to a staff member or their relatives if they had any concerns or were dissatisfied with any aspect of the service they received.

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

Capacity and capability

This inspection found that although the provider had completed significant works to improve fire safety in the centre, the management and clinical oversight systems in place did not ensure that the service was effectively managed to the benefit of many of the residents who lived there. As a result, residents' care and safety needs were not adequately met, and their quality of life was not optimised in accordance with the designated centre's statement of purpose (SOP).

The registered provider of Newbrook Nursing Home is Newbrook Nursing Home Unlimited Company, and the designated centre is registered to accommodate up to 119 residents. The provider is represented by a company director who is involved in the running of and regularly attends the designated centre. The person in charge is supported in their role by a regional operations manager. Locally, the person in charge is supported in their day-to-day role by an assistant director of nursing and

two clinical nurse managers. A clinical nurse manager and a team of nursing staff, health care assistants, activity, housekeeping, catering, laundry, and maintenance staff were provided in each of the two buildings comprising the designated centre, known as Newbrook One and The Lodge.

Although the registered provider had varied systems in place to monitor the quality and safety of the service, these systems were not effectively identifying deficits in the quality of service provided to residents, in care delivery, and in residents' safety in the centre. This is discussed further under Regulation 23: Governance and Management..

The staffing systems in place did not ensure that there was enough staff with the necessary skills to meet residents' clinical and social care needs. The provider employed a dedicated regional trainer to support mandatory training and the professional development training needs of staff. However, the systems in place to monitor and supervise staff to ensure they each carried out their work to the required standards were not effective. The inspection findings are discussed further under Regulation 15: Staffing and Regulation 16: Training and staff development.

While the provider has processes and procedures in place for recording, investigating, and managing accidents and incidents involving residents, these did not always inform learning or effective actions to mitigate the risk of recurrence. Furthermore, not all incidents involving residents, as specified in the regulations, were notified to the Chief Inspector of Social Services as required.

Schedule 5 policies and procedures, along with other policies, were available to staff and updated at intervals not exceeding three years, but a number of these policies were not being implemented by staff. This finding is discussed under Regulation 4: Written policies and procedures.

The provider had arrangements in place to ensure each resident had an agreed contract of care and service that described the terms and conditions of their residency in the designated centre. The inspectors reviewed a sample of residents' contracts and found that several of these contracts included additional charges for services that residents should have received free of charge through the General Medical Services (GMS) scheme or other entitlements.

Regulation 14: Persons in charge

The person in charge commenced in their role in July 2025, and their management experience and qualifications meets the requirements of the regulation.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that there were sufficient numbers of staff with appropriate skills available to meet residents' needs. This was evidenced by the following inspection findings;

- There were not enough staff with appropriate skills available to ensure that residents who stayed in their bedrooms were provided with adequate opportunities to participate in a meaningful social activity programme in line with their individual interests and capacities. As a result, these residents did not have opportunities to participate in any meaningful social activities on the day of the inspection.
- Staff were not available at all times to respond to residents' needs for assistance and support in one of the communal sitting rooms in Newbrook One building, where residents spend most of the day. The inspectors observed that a number of residents in this communal room were resting in high-support wheelchairs, had an assessed risk of falling; however, there was a limited supervision in place.
- Inspectors observed many occasions where there was a delay in staff responding to residents' requests for assistance. For example, inspectors noted that residents' call-bells were ringing for prolonged periods, and a number of residents asked the inspectors in both buildings to ask staff on their behalf to attend to their needs. An example was a resident in the smoker's room in the Lodge, where there was no heating, who was calling out for staff assistance and reported to the inspectors that they felt cold.
- Systems were not in place to ensure unplanned staff absences were promptly communicated to and replaced by the person in charge. For example, the person in charge was not aware that two staff members were absent on unplanned leave in the Newbrook Lodge building on the day of the inspection. As a result, there were insufficient numbers of staff available to meet residents' needs.

Judgment: Not compliant

Regulation 16: Training and staff development

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

- Staff were not adhering to safe moving and handling procedures. The inspectors observed unsafe moving and handling procedures during the transfer of one resident to a wheelchair.
- Staff were not responding in a timely manner to residents ringing their call-bells for assistance. The inspectors observed that residents' call-bells were

ringing for periods up to 10 minutes throughout the day, and the inspectors had to seek assistance on behalf of residents from staff on several occasions during the day of the inspection. On other occasions, while staff members were observed in the corridors, they did not attend to residents who were seeking assistance. These findings concurred with feedback from a number of residents who spoke with the inspectors.

- Nursing staff were not administering residents' medications in line with professional requirements and the centre's medication administration policy.
- Residents in all the communal sitting rooms and residents who wished to remain in their bedrooms were not provided with adequate opportunities to participate in meaningful social activities in line with their interests and capacities.
- Residents' care documentation was not completed to the required standards, and in line with the centre's policies and procedures. This was negatively impacting on staff knowledge regarding the care each resident needed to meet their needs and the standard of care residents were receiving.
- Two students in the centre on placement were not appropriately supervised and were assisting with care procedures that they did not have the necessary skills and knowledge to complete.
- Staff were not assessing residents' skin integrity issues in line with evidence-based practice.

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

Judgment: Not compliant

Regulation 21: Records

A selection of staff files was reviewed during the inspection. All required documents, as outlined in Schedule 2, were available and met the criteria of the regulation.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not ensure that the designated centre had sufficient staff resources to ensure the effective delivery of person-centred, care in accordance with residents' needs and the designated centre's statement of purpose, and this was negatively impacting on residents' care delivery and their safety in the centre. The findings of this inspection evidenced that the current management

systems in place did not ensure that there was effective oversight of staff resource allocation, staff practices and the standards of care delivery to residents.

The governance and management systems in place did not adequately ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored regarding the following findings on this inspection. For example, high levels of compliance reported in the centre's own care plan and call-bell response times audits did not reflect the inspectors' findings. Furthermore, evidence was not available that incidents affecting residents' skin integrity were analysed and trended to inform improvement plans.

The deficits in the provider's governance and management oversight of the centre were further evidenced by the following findings;

- There was insufficient oversight and monitoring of incidents involving residents. Inspectors reviewed the incidents to residents' skin integrity that occurred in the centre since September 2025. This information identified a high number of wounds and injuries that occurred to residents' skin, and included wounds that were not identified as pressure ulcers in line with evidence-based pressure ulcer classification guidelines. As a result, there was limited evidence available that the assessment of these wounds informed effective care delivery and management, including appropriate referral for medical and tissue viability specialist expertise.
- Management oversight and systems did not ensure that safe care was provided to residents, as the management was not aware that there were volunteers in the centre on the day of the inspection, or that there was s shortage of the staff.
- The management systems for staff supervision and oversight of their practices to ensure they carried out their work to the required standards and in line with the centre's policies and procedures were not effective, as evidenced under Regulation 16: Training and staff development and Regulation 4: Written policies and procedures.
- Assessment and care planning procedures were not implemented in line with the provider's own policy and procedures and the requirements of the regulations. As a result, the standards of residents' care documentation were not adequate, and posed a risk that relevant up-to-date information regarding each resident's needs and care interventions was not available to staff. These findings are discussed further under Regulation 5: Assessment and care plan.
- The provider had not ensured that residents had opportunities to participate in meaningful social activities to meet their needs. This is discussed under Regulation 9: Residents' Rights.

The provider's management of risk in the centre was not effective, and as a result, the systems in place to identify, manage and respond to risk and ensure residents' safety were not adequate as follows;

- Significant risks were identified on the day of the inspection in the preparation and serving of meals and the assistance provided to residents at mealtimes. As a result, some residents did not receive food in line with their

assessed needs. This is further outlined under Regulation 18: Food and nutrition.

- The provider's risk management systems were not effective and as a result, there was inadequate evidence that a serious incident involving a resident was appropriately investigated and effectively managed to ensure that the likelihood of recurrence was effectively mitigated. The inspectors found that the incident was closed without any appropriate investigation or actions taken to ensure learning was identified and that the risk of the incident reoccurring was removed. Therefore, the inspectors requested the provider to carry a serious incident review on the day of the inspection to ensure residents' safety. The provider submitted this review to the office of the Chief Inspector following the inspection; however, the actions identified failed to address a number of key factors contributing to and following the incident. Consequently, the learning opportunities and the action to prevent further occurrences were not adequate.
- The management and oversight systems had failed to identify risks in respect of medication administration practices. The inspectors' findings are discussed further under Regulation 29: Medicines and pharmaceutical services.

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

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The terms and conditions regarding additional charges stated that the additional weekly charges included costs for physiotherapy and dietetic services. However, some residents may be entitled to physiotherapy and dietetic services free of charge through the General Medical Services (GMS) scheme or other entitlements.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications and quarterly reports were not submitted as required and within the time frames as specified by the regulations. For example;

- An NF01 notification was not submitted to notify the Chief Inspector of a resident's unexpected death in January 2026.

- The reports for the third and fourth quarters of 2025 regarding pressure ulcers did not accurately reflect all incidents that occurred during that period.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All policies and procedures as outlined in Schedule 5 were available in the centre.

Judgment: Compliant

Quality and safety

Overall, the inspectors observed that all staff treated residents with respect and kindness. Staff aimed to meet residents' needs, but this inspection found that improvement actions were necessary to ensure residents' health and nursing care needs were met to the required standards. Additionally, not all residents were adequately supported to participate in meaningful social activities that met their interests and were in line with their individual capacities and preferences.

Most of the residents had timely access to their general practitioners (GPs) who visited them as necessary in the centre. An on-call GP service was also available to residents with medical needs that occurred outside of normal working hours. While the provider had measures in place to ensure residents had access to additional health and social care professional expertise to meet their needs, effective arrangements were not in place to ensure that treatment recommendations made by speech and language therapy professionals were implemented and monitored. Furthermore, the inspectors also identified that not all residents were appropriately referred for additional expertise in a timely manner to support their skin integrity needs and care delivery. These findings are discussed further under Regulation 6: Health care.

Residents' care needs were assessed, and most of their care plan documentation provided guidance for staff on the care they must provide for each resident in line with their individual needs and preferences. However, a number of residents' wounds were not adequately assessed, and this resulted in deficits in residents' care plans to direct staff on evidence-based wound care and prevention of deterioration procedures. Furthermore, residents' nutrition care plans were not kept up-to-date and were not implemented in line with the recommendations of the speech and language therapist. As a result, the residents' care documentation reviewed on this inspection could not be relied on to clearly direct staff on the care they must provide

to meet each resident's needs. This finding is discussed further under Regulation 5: Individual Assessment and Care Plan and Regulation 18: Nutrition.

Notwithstanding the significant works completed by the provider to ensure residents were protected from the risk of fire, actions were found to be necessary to ensure each resident's safe evacuation needs would be met in the event of a fire in the centre.

The inspectors again found during this inspection that the provider had not ensured that many residents were provided with adequate opportunities to participate in meaningful social activities that interested them and that met their individual capabilities. Although staff mostly remained with residents in the communal areas, this arrangement did not support residents' social care provision. As a result, this was having a negative impact on residents' quality of life and did not ensure their rights were respected.

Medication administration practices did not align with best practices and professional guidelines, and practices observed by the inspectors posed risks to residents' medication administration safety. This finding is discussed under Regulation 29: Medicines and pharmaceutical services.

Regulation 18: Food and nutrition

The dietary needs of residents, as prescribed by health care or dietetic staff, based on nutritional assessment, were not consistently met. For example:

- A resident who was prescribed by the Speech and language therapist (SALT) for a soft and bite-sized diet to meet their needs was instead served a pureed diet.
- Two residents prescribed a minced and moist diet to meet their needs were instead given a pureed diet.
- A resident was prescribed Level 3 moderately modified fluids to mitigate their risk of aspiration, had regular thin fluids been served to them.

Residents' meals were not appropriately prepared and served. For example:

- The person who prepared and served residents' food and fluids for breakfast and lunch time did not have the appropriate training in the safe handling of food, dysphagia (difficulty swallowing, representing a disorder where food or liquid takes more time and effort to move from the mouth to the stomach) and was not provided with an overview of residents' diets and fluids. In addition, this person did not have the requisite knowledge or training to assist residents assessed as having high dependency needs and dysphagia.

All residents were not offered a choice at mealtimes. For instance:

- Residents had their meals pre-plated, with staff routinely pouring juice, milk or tea into their glasses without offering an alternative.
- The lack of choice was also evident in the absence of tablecloths, menus, and condiments on some dining tables.
- Additionally, extra sauce, salt, pepper and butter were not available for those who might have preferred them. Residents were observed asking staff members to bring these condiments to them.

These practices were identified as immediate risks by the inspectors on the day of the inspection during breakfast time, and it was brought to the attention of the person in charge. The manner in which the centre responded to the risk did not provide assurances that the risk was adequately addressed, as inspectors observed the same practices recurring at lunch time. Therefore, the provider was required to submit an urgent compliance plan to address the urgent risk to residents. The provider's response did not provide assurances that the risks were adequately addressed.

Judgment: Not compliant

Regulation 28: Fire precautions

Although regular emergency evacuation drills were completed, the provider had not ensured that the evacuation needs of a resident in the Newbrook Lodge building, who needed the assistance of three staff to support their emergency evacuation to a place of safety, could be met, given that there were only four staff available during the night in this building. Staff told the inspector that additional assistance would be provided by staff in the nearby Newbrook 1 building in the event of a fire emergency in the Newbrook Lodge building. However, staff were not aware of this arrangement or regarding the number of additional staff that would be available. Furthermore, this arrangement was not described in the centre's fire evacuation policy or referenced in the records of the emergency evacuation drills completed.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors observed examples where medication administration and storage practices did not align with best practice and professional guidelines issued by An Bord Altranais agus Cnáimhseachais. The following findings posed a risk to residents' safety;

- Some of the residents' medical administration records were photocopies, which had not been signed by a prescriber.

- Some of the residents' medical administration records were photocopies and contained illegible resident data; the resident's name was printed in very small font, and the residents' date of birth and photograph were not included.Inspectors found expired medications that were no longer required for residents, and the date of opening was missing for some medications with a specified limited lifespan once opened.
- Medication trolleys were not appropriately secured to a wall when not in use, and the keys were consistently left in the trolleys.
- During medication administration rounds, inspectors observed that medication trolleys were left unsupervised in corridors, with the doors partially open, or unlocked with keys left in the lock. This posed a significant risk to residents' safety.
- Nurses did not bring the medication trolleys to the residents' bedrooms during medication rounds, but instead left them in corridors or in the treatment/clinical rooms, while they administered medications from medication cups, which they held in their hands or stored in the front pocket of their aprons. The inspectors observed that nurses administered medications in medicine cups stored in a pocket in their apron to up to three residents simultaneously. This practice is not in line with best practice for administering residents' medications and poses a significant risk to residents' safety.
- Medication administration records were all pre-signed before the medications were administered to residents.

Under this regulation, the provider was required to submit an urgent compliance plan to address the significant risks identified to residents' safety. The provider's response did provide adequate assurances that the risks were effectively addressed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors found that significant action was required to ensure that care plans were based on assessed needs and reflected residents' current condition. This was evidenced by the following findings:

- Residents had care plans for their nutritional needs, but some of these plans had not been updated after reviews by health professionals. Consequently, these care plans did not provide details regarding the recommended consistency of food and fluids for the residents.
- In all of the care plans reviewed, the personal needs of residents were not identified and were missing.
- Care plans addressing skin integrity had not been updated to reflect documented wounds, such as moisture lesions or pressure ulcers, nor did they include plans for wound dressing, repositioning protocols and care.

- Some care plans contained historical data on incidents involving residents and recommendations from health professionals for their care. This could lead to confusion in the delivery of care.

Judgment: Not compliant

Regulation 6: Health care

There were examples of nursing practices in the areas of residents' assessment and care documentation, and medication administration that did not meet the necessary standards to ensure residents received high-quality, evidence-based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnaimhseachais. For example:

- Residents' medications were not stored and administered in accordance with professional guidelines issued by An Bord Altranais agus Cnaimhseachais.
- The inspectors found that a resident had not been repositioned for several hours. This omission in their care increased their risk of developing pressure-related skin damage and discomfort. In addition, the repositioning record was inaccurately signed by staff, indicating that the resident had been turned twice during the period observed when, in fact, they had not.
- Nursing staff did not adequately monitor residents' clinical well-being after sustaining serious injuries or following an episode of unconsciousness, as their vital signs and neurological observations were not regularly assessed to identify clinical deterioration.
- Residents' food and nutrition were not provided in line with the recommendations of speech and language therapy specialists, further to their assessments of residents' needs.
- Residents with pressure-related wounds, one of which was described as a necrotic wound were not assessed as pressure-related wounds in line with evidence based practice. As a result, residents' needs to promote wound healing, and to prevent further deterioration were not assessed.

Residents' needs were not sufficiently recognised, and as a result, residents were not regularly referred to the health services for additional professional expertise. For example:

- Residents with pressure-related skin wounds were not appropriately referred for relevant health care professional expertise. This finding posed a risk that residents would not receive the appropriate care and treatment they required.
- A resident who sustained an injury in the centre was not appropriately referred for a medical or general practitioner (GP) review until the next day following their injury. Medical expertise was only sought over the phone after the resident had experienced an episode of unconsciousness.

Judgment: Not compliant

Regulation 9: Residents' rights

The residents in Newbrook One did not have access to social activities that interested them and that were in line with their preferences and capabilities. For example:

- The inspectors observed that the majority of the residents in the communal rooms, and those who stayed in their bedrooms, were not provided with opportunities to participate in meaningful social activities to meet their individual preferences and capacities. Although staff were observed to be present with residents in all but one communal room on the day, the staff did not involve themselves in facilitating social activities for the residents, and there was a dependence on television viewing. Many of the residents were observed to be intermittently sleeping or quietly sitting in comfort chairs, watching the 'comings and goings' of staff and other people moving around the rooms. This was not in line with any of the residents' assessed social care preferences, and the inspectors' observations concurred with feedback from many of the residents who spoke with them.

Residents' right to privacy when receiving their medications was impacted by staff administering residents' medicines in the dining rooms during mealtimes.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Newbrook Nursing Home OSV-0005702

Inspection ID: MON-0046741

Date of inspection: 12/02/2026

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:
Activities:
Since Inspection the PIC has reviewed the Activities programme in conjunction with the Activities Co-ordinator to address the aspects of the service that required improvement. The following has been implemented:

• An additional activities person has been recruited for Newbrook Lodge. We have also increased the activities hours by two per day.
• Activities programme has been reviewed and updated paying particular attention to residents with high / max dependency and residents who wish to remain in their bedroom.

Staff levels have been reviewed based upon the assessed needs of the residents. There are sufficient staff currently on the roster with no vacancies as at 27/03/26. However, we are reviewing the skill mix and the supervision arrangements to ensure that they are meeting the needs of the residents. In addition to senior HCAs, three staff nurses plus a CNM, for an average occupancy of sixty residents, are available to supervise care practices in Newbrook One.

We have adjusted the staffing allocation per shift as required to ensure a continuous staff presence. We aim to ensure a call-bell response within two minutes. We have assigned senior carers to take charge and to ensure call bells response protocol is followed daily. This is monitored by PIC.

All staff Absences to be highlighted and reported at handover. All absences and shortages will be escalated to the PIC/ADON/CNM in charge immediately. On-call staff will then be contacted to fill the shift.
Unplanned staff absences are managed through a clearly defined and implemented escalation process. All absences are reported immediately to the Nurse in Charge at the start of the shift or as soon as they arise and are formally communicated during handover to ensure continuity.

The Nurse in Charge escalates all absences without delay to the Director of Nursing (Person in Charge). A live on-call staffing list is in place and actively used, and on-call staff are contacted immediately to fill in the vacant shifts. Where required, escalation continues to ensure replacement staff are secured in a timely manner.
To provide assurance of effective management:
· The Person in Charge reviews absences and response times daily to ensure timely cover and identify any delays or patterns.
· Escalation timelines have been defined, with immediate action required on notification of absence and ongoing escalation until the shift is filled.
· Staffing contingencies are in place, including access to additional staff on call to ensure safe staffing levels are always maintained.
· Compliance is monitored and reviewed, and any delays in securing cover are addressed promptly with corrective actions implemented.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A comprehensive training needs analysis was completed on 20/03/2026, informed by inspection findings.
A training plan has been implemented including
• Mandatory Training (All Staff)
• Nursing-Specific Training
• Staff who have not completed required training are not assigned duties beyond their competence and are directly supervised until training is completed.
• Monthly audits of training compliance and supervision practices are conducted, with findings informing ongoing quality improvement.
• Training is incorporated into staff induction and ongoing professional development plans.
• Refresher training schedules have been established to ensure continued compliance.
• Supervision and training compliance are standard agenda items at management and governance meetings.
We have the following training to address skill deficits as identified during the inspection:
Mandatory training for all staff:
• Manual handling.
• Pressure ulcer Prevention & Wound care
• Falls prevention, safe mobility and falls management.
• Safeguarding vulnerable adults.
• Infection Prevention & Control.
• Dysphagia.
Nurses training:
• Clinical Risk Assessments

• Medication management both online and Classroom based (classroom Scheduled for 26th March ,22nd April ,29th April)
• Care planning 1;1 on site by CNM during Induction.
• IRRESTORE: Recognising deterioration (2 staff enrolled in IRESTORE Facilitator training programme scheduled for 23rd March). This programme will then be rolled out onsite to all nurses by the facilitators in May 2026 and plan to go "live "on 1st June 2026.This tool will be available on the current Computerised nursing system .
• Care of Deteriorating Resident study day (Planned on site -scheduled for May 26th - June 9th, June 16th 2026)

Manual Handling:
• All staff must complete up-to-date manual handling training (100% compliance by 30/04/2026) and demonstrate practical competency before undertaking resident transfers independently. Untrained or non-competent staff do not carry out manual handling unsupervised.
• Individual risk assessments and care plans clearly outline required equipment and staffing for all transfers, and staff are required to always adhere to these.
• Supervision is in place on each shift by Clinical Nurse Managers and senior staff, supported by regular unannounced spot checks by the Person in Charge and Health and Safety Officer.
• A monthly audit programme monitors compliance, with immediate corrective action and retraining where required. Incidents are reviewed to inform learning.
Call Bells:
• Call bells are now prioritised as an immediate response, with an expected response time of under 2 minutes, and immediate attendance for high-risk or dependent residents.
• Supervision has been strengthened, with a designated staff member on each shift responsible for call bell oversight, supported by active real-time supervision from Clinical Nurse Managers, staff nurses and senior HCAs. Failure to respond promptly is addressed immediately.
• A daily monitoring and weekly audit system is in place, overseen by the PIC. Delays are escalated and addressed through immediate corrective action, staff reallocation, and retraining where required.
• Staff deployment has been adjusted to ensure continuous visibility and presence in all areas, particularly during peak times.

Medication Management:

Following inspection, the PIC has recognised the deficits in practice and is addressing these issues with a proactive approach.

• All nursing staff to complete medication management training and are required to demonstrate competency through supervised practice and formal competency assessment prior to administering medications independently. Staff who have not demonstrated competence do not administer medications unsupervised. All Nurses will complete Online Medication Training for 2026 as a matter of urgency. Additional classroom-based medication training is scheduled for 26th March 2026 and later in Quarter Two 2026 when dates are available.
• Robust supervision arrangements put in place, with the Director of Nursing (PIC), ADON, Clinical Nurse Managers, and Practice Development Nurse providing direct

oversight of medication administration in practice. This includes supervised medication rounds, real-time observation, and immediate corrective intervention where required.
• A structured medication audit programme has been implemented, including regular medication round audits and spot checks, focusing on safe administration, adherence to the "Ten rights", and accurate documentation. Audit findings are reviewed by the Person in Charge, and any identified deficits are addressed promptly through retraining, supervision, and reassessment of competency.
• Medication practices are delivered in line with Nursing and Midwifery Board of Ireland professional guidance and the centre's medication management policy. Compliance is monitored on an ongoing basis through audit, supervision, and governance review.
• The PIC will meet with the Nurses and discuss deficits in current practices and discuss plan for improvement. All nurses will be reminded of their nursing obligations and conduct in line with NMBI Guidance for Registered Nurses and Midwives on Medication Administration (2020).

• Care Plans: The PIC and COM have reviewed all Residents care plans with audits and corrective actions since inspection to ensure all documentation is clear, up to date for staff to follow and provide residents plan of care in a safe and timely manner. The Practice Development officer will provide ongoing support and guidance to nurses in this area of documentation going forward.
• Documentation: A Practice Development Nurse has been recruited and has commenced in post on 23rd March 2026. The Practice Development Officer will develop and support nursing practice for Newbrook. This will be achieved by onsite presence and support the PIC with the clinical supervision and oversight. Gaps in documentation or practice will be addressed with teaching and learning to ensure a high standard of nursing care with scope for quality improvement. The CNM and PDO will carry out medication round observational audits with the staff nurses to improve practice and feedback directly to the PIC.

Activities:

An additional activities person is being recruited for Newbrook Lodge. In the interim activities hours have increased by two hours. The activities programme has been reviewed and updated paying particular attention to residents with high / max dependency and residents who wish to remain in their bedroom. Clear instructions have been given to staff and residents about what activities are available in the Centre. The activities team will monitor involvement and seek feedback from the residents. These provisions should ensure that residents who choose to remain in their bedrooms will be provided with a meaningful activities programme.

The DON (PIC) will meet with the Activities Coordinator at the start of each week to discuss the plan for that week and reflect on the previous week. The PIC will oversee the activities programme to ensure that all residents have access to recreation and opportunities to participate in activities of choice in accordance with preference and abilities in line with the Health Act.

The Activities Team will report directly to the PIC and the PIC will regularly review the

activities programme to ensure that it meets the assessed needs of the residents.
The PIC will attend the Residents meeting to hear the lived experience of residents and hear feedback in relation to the service provided.

Care Documentation:

Care Plans: The PIC and Clinical Operations Manager have identified gaps in documentation and information in resident care plans. The PIC has directed each Named Nurse to update the care plans with accurate and current information. The CNM's will review this daily and feedback to the PIC to monitor compliance going forward. The PIC and Clinical Operations manager will audit the current care plans and feedback to the nursing team with areas that require improvement. The PIC will discuss Care Plans at Nurses Meeting and daily handovers.
Multidisciplinary Team MDT :The recommendations of the MDT will be documented in the care plan, and this information will be shared at daily handover. All staff have access to the care plan, so they can deliver appropriate and safe individualised person-centred care. Changes to care plans will also be verbally communicated to staff at daily handovers.

Handover: The COM will review morning handovers in conjunction with the DON (PIC), ADON and CNMs to identify gaps in information. The PIC/ADON/CNM will supervise the standard of Nursing communication at the handover to ensure residents receive a high standard of nursing care.
The Nurses Handover sheet will be updated nightly and verbally handed over to the nursing and care team daily to reflect clinical recommendations and any changes to current condition of residents.

Pressure Area Care
All residents are undergoing a comprehensive skin integrity assessment, including visual inspection, completed by the senior clinical team (PIC, ADON, CNMs). High-risk residents are identified using validated risk assessment tools and prioritised for intervention. TVN referrals will be sent for existing skin integrity issues for repeat review. TVN will have an input into these assessments as appropriate. High risk residents will be identified and prioritised for intervention.
Staff competency has been strengthened. All nursing staff are required to complete pressure ulcer prevention and skin assessment training with TVN, followed by competency assessment in practice. Staff who have not demonstrated competence are not permitted to undertake assessments independently and are supervised. This will be overseen by the PIC.
The need for additional training is determined through a structured approach, including:
• Findings from care plan and skin integrity

Regulation 23: Governance and management	Not Compliant

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

A strengthened governance framework is now in place, with clear lines of accountability from the CEO, Clinical Operations Manager (COM), and Person in Charge (PIC) to the wider management team.

• The PIC, ADON and CNMs provide daily operational oversight, including supervision of staff practices, staffing allocation, and risk management.

• The COM provides on-site governance oversight (minimum two days per week), focusing on supervision, audit, and compliance.

• The Provider has employed a Practice Development Nurse who commenced on 23rd March 2026. This role will provide additional clinical oversight and training where required based on audits, incidents and accidents and care planning. The Practice Development Nurse will work closely with the COM, the Quality, Safety and Risk Manager and the Health and Safety Officer to supervise and uphold clinical standards and feedback to the Provider monthly.

• When PDO commences role on 23-03-26, she will provide on site training and support to staff (Minimum two full days weekly).

• The CEO, COM and PIC meet weekly to review governance arrangements, including:

o Staffing resources and skill mix

o Clinical risks and KPIs

o Incidents and safeguarding concerns

o Audit findings and compliance levels

o Progress and effectiveness of action plans

The Provider in conjunction with the PIC and COM has investigated and reviewed clinical risks and incidents in the center. To address any gaps in practice or communication the following actions have been implemented to improve practice and oversight:

Handover: The COM attends morning handovers in conjunction with the DON (PIC), ADON and CNMs to assess if the handovers are being carried out in line with the Centre's Handover Communication Policy. We are improving handover practices to ensure that every shift handover is clear, consistent and focused on the risks to residents, changes in their baseline and actions that need to be taken to ensure the required standard of care delivery. Handover will highlight staff shortages to the PIC/ADON/CNM as a matter of urgency. The PIC will be informed of all shortages or disruption to the roster so as to ensure staffing levels and skill mix are in line with the statement of purpose. Staff shortages will be reviewed daily.

Supervision and Oversight of Practice

• The COM, the DON (PIC), the ADON and the CNMs will work with the staff nurses to support them, to supervise their practice and to make them aware of their responsibilities to supervise care practices of the HCAs.

• Clinical Operations: The Clinical Operations Manager will work on site at a minimum of two days a week to support the PIC in the Governance and Management of the centre and all quality improvements.

• Practice Development Nurse has been recruited and will commence the role on 23rd March 2026. PDN will spend a minimum of two days a week on site to facilitate additional training and support for the staff. The PDN will also carry out observation of staff

practice and provide additional feedback to the PIC. The PIC and the PDN will then implement immediate corrective measure to ensure all staff are carrying out care practice in line with nursing homes policy and procedures.
• A CNM is on site 7 days a week and will carry out spot checks to ensure the required standard of care delivery and feedback to the PIC .

Senior Management Supervision
In addition, the Provider will meet with the PIC and COM weekly to:
• Review the governance arrangements in the Centre.
• Review weekly KPIs and clinical risks.
• Review accidents and incidents.
• Review Safeguarding risks or incidents.
• Review risk register.
• Develop action plans and review their effectiveness.
• Make quality improvements.

Risk Management:

The CEO, COM and Quality Manager review all incidents and accidents on a regular basis in line with our Incident and Accident Policy. All incidents will have a full investigation to include factual description, contributory factors, risk/controls, actions taken, documents attached, future actions required, revaluation, learning and feedback. The CEO and COM will review and supervise the documentation and content of all incidents, accidents and near misses.

Volunteer Policy:
Following inspection, the PIC has reviewed the implementation of the Volunteer Policy. The role of volunteers as documented in the Policy will be adhered to. The PIC will be directly involved with all volunteers. In line with the current policy all volunteers will have their roles and responsibilities set out in writing and supervised appropriate to their role.

Medication Management:
The PIC has reviewed the medication administration, systems and practice in the centre. Following inspection, the PIC has implemented the following
• Training: All Nurses to complete Online medication training. Additional classroom-based medication training is scheduled for 26th March 2026.

• Supervision: The senior Nursing team (PIC, COM, ADON, CNM) will audit, observe and supervise the staff nurses to support them to maintain medication Management in line with the current NMBI guidance for Nurses in Medication Administration (2020). All nursing staff will be supervised in practice.

• Regulation: All Nurses made aware of their responsibilities under the professional guidelines issued by the Nursing and Midwifery Board of Ireland. The PIC/CNM will conduct medication Competency Audit on each individual nurse to ensure safe practice.

• Audit: PIC/COM will conduct spot checks and carry out medication round audits with the staff nurses. Feedback and learning from this will help to improve practice.

• Ongoing Assessment: The Practice Development Nurse PDN when in post (23rd March) will carry out medication round audits with the staff nurses to supervise and ensure compliance and a high standard of nursing practice with medication administration and management. PDN once in post will provide 1-1 training with all staff nurses.

Skin Integrity:

Following this inspection the PIC has implemented the following to address the issues identified:
• A Serious Incident Review of wounds and skin injuries from the 1st September 2025 will be carried out by the Clinical Operations Manager COM in conjunction with the PIC and ADON. The findings will be discussed with the Tissue Viability Nurse TVN. Learning from this review will be implemented immediately by the PIC with oversight by the COM.
• Care Plans: The PIC and COM have reviewed the current Skin Integrity care plans to ensure evidence-based practice is being implement. PIC will ensure accurate wound assessments and evaluations are being carried. The care plan will be communicated to staff, and it will guide them in care delivery. Would process monitored closely. For those residents with Skin Integrity Risks the care plan will address the plan of care for each resident

Activities:

The PIC has reviewed the Activities programme with the Activities co-ordinater. To address the overall, activity programme the following interventions have commenced:
• The activities programme has been reviewed and updated paying particular attention to residents with high / max dependency and residents who wish to remain in their bedroom. Clear instructions have been given to staff and residents about what activities are available in the Centre. The activities team will monitor involvement and seek feedback from the residents. These provisions should ensure that residents who choose to remain in their bedrooms will be provided with a meaningful activities programme.

Food and Nutrition:
Following inspection, the PIC and COM have reviewed the mealtime experience. The
• Supervision
• Documentation
• Food preparation/Serving
• Choice
• Training
• Dietary
• Communication

have all been reviewed and addressed with oversight arrangements now in place.

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:
All contracts issued since June 2024 have no physio or dietic services included in the ancillary service charge. Older contracts have now been amended to reflect these changes also.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Following inspection, the PIC has reviewed the incidents and accidents.
All deaths since 1st January 2025 have been reviewed and NF01s submitted where necessary.
NF39E for the previous quarter has been reviewed by the PIC. Following this review by the PIC two additional Pressure Ulcers have been reported in retrospect of Quarter 3 2025 to the Chief Inspector.
The COM is in the process of conducting a critical incident review of all wounds and skin injuries as requested and this report will be submitted to the Chief Inspector when completed. Any additional Pressure Ulcers will be submitted in line with regulations.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

Immediate Risk Control
• All residents' dietary requirements and fluid consistencies have been urgently reviewed and verified against Speech and Language Therapy (SALT) and dietetic recommendations.
• A standardised, up-to-date diet and fluid list is now in place in the kitchen and dining areas, checked at the start of each shift by the nurse in charge. All staff have access to this information when in the dining area or access via care plan.
• Only appropriately trained staff are permitted to prepare, serve, or assist with food and fluids. Untrained staff have been removed from these duties.
• The nurse in charge supervises all mealtimes, ensuring residents receive the correct

diet and fluids as prescribed.

Training and Competency All relevant staff grades (nurses, HCAs, catering staff) are required to complete:
o Dysphagia and safe feeding training (aligned with national guidance) – to be completion by 05/05/2026
o Food safety and safe meal service training – to be completion by 05/05/2026
• Staff must demonstrate competency in practice (correct meal consistency, safe assistance, correct fluids) before undertaking these duties independently.
• Staff who have not completed training or demonstrated competence are not permitted to prepare, serve, or assist residents with meals unsupervised.

Supervision and Mealtime Oversight
• The nurse in charge and CNMs provide direct supervision at all mealtimes, ensuring:
o Correct diets and fluid consistencies are served
o Residents requiring assistance are supported safely
o High-risk residents (e.g. dysphagia) are prioritised
• Unannounced mealtime observations are conducted by the PIC/ADON/COM to monitor staff practice in real time.
• Any unsafe practice is addressed immediately through intervention, supervision, and retraining.

Mealtime Experience and Choice
• Residents are now offered choice at each mealtime, including meal options and drinks.
• Meals are not pre-plated without consultation, and residents are supported to make choices where required.
• Dining environments have been improved to ensure availability of:
o Menus
o Condiments (salt, pepper, sauces, butter)
o Appropriate table settings
• Staff are supervised to ensure that choice, dignity, and independence are promoted at all times.

Monitoring, Audit and Assurance
• A daily mealtime checklist is completed by the nurse in charge to confirm:
o Correct diets and fluids served
o Staff supervision in place
o Resident choice offered

• Weekly audits of mealtime practices are conducted by the PIC/ADON, focusing on safety, compliance, and resident experience.
• Audit findings are reviewed at governance meetings, and immediate corrective actions are implemented where required.
Sustainability
• Mealtime safety and nutrition are standing agenda items at governance meetings.
• Ongoing supervision, audit, and refresher training ensure sustained compliance.
• Learning from incidents and audits is shared with staff and embedded into practice.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A full compartment evacuation drill has been completed using night-time staffing levels, simulating residents with varying dependency needs, including high-dependency profiles.
• The drill tested the capacity of 4 staff on night duty to evacuate all residents to a place of safety.
• Findings identified the need to strengthen skills in evacuation procedures and staff allocation during emergency scenarios.
As a result:
• A revised evacuation plan is in place, clearly outlining staff roles, prioritisation of residents, and staged evacuation procedures.
• Staff allocation during evacuation has been redefined to ensure both safe evacuation and ongoing supervision of residents.
• Additional control measures have been implemented, including prioritisation protocols and use of appropriate evacuation equipment.
Further repeat drills are scheduled (including unannounced drills) to validate that evacuation can be completed safely and effectively with available staffing levels.
Clarity of Emergency Response and Staffing Support
• The Fire Evacuation Policy has been reviewed and updated to clearly define that each unit operates independently in the event of a fire, unless formally escalated through emergency services.
• All staff have received clear instruction that no reliance is placed on staff from other buildings unless this is part of a formally defined and tested procedure.
• This clarification has been communicated to all staff and reinforced through fire training and drills.
Training and Staff Competency
• All staff are required to complete fire safety training, including practical evacuation procedures, with 100% compliance monitored.
• Fire drills are conducted regularly, including night-time scenarios, to ensure staff are competent and confident in evacuation procedures.
• Staff competency is assessed during drills, with additional supervision and retraining provided where required.

Monitoring and Assurance
• All fire drills are formally recorded, reviewed, and signed off by management, including evaluation of staffing effectiveness and response times.
• Learning from drills is used to update evacuation plans and staff training.
• Fire safety and evacuation capacity are reviewed at governance meetings, ensuring ongoing oversight and compliance.

Communication: It has been communicated to all staff at Fire training and Fire drills, at handover and team meetings about the Fire Evacuation Procedure. The PIC and the training officer have clarified to all staff that additional assistance will not be provided by staff in the nearby building. This is in line with our Fire Evacuation Policy.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

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

Medication Management:

Following inspection, the COM and PIC have idenfitfed gaps in practice and plan to implement the following:

• Training: Nurses will complete Online medication training. Classroom-based medication training is scheduled for the 26th of March 2026,

• Policy: All nurses will read the nursing home Medication Policy and follow the correct procedure in line with the 10 rights of medication (NMBI guidelines 2020). This will be overseen by DON and addressed at all handovers and nursing team meetings.

• Support & Supervision: The COM, the DON (PIC), the ADON and the CNMs will work with the staff nurses to support them, to supervise their practice and to make them aware of their responsibilities under the professional guidelines issued by the Nursing and Midwifery Board of Ireland. Spot checks to be carried out by PIC/COM. Feedback and learning from these audits will be communicated back to all staff nurses and form quality improvements. Any issues identified will be addressed with individual staff members immediately.

• Audit: The COM will audit the current medication practice. The Practice Development Nurse when in post in March will continue to carry out medication round audits with the staff nurses to improve practice.

• Pharmacy Support: The PIC has discussed the resident's documentation records, and this is being addressed as a matter of urgency to ensure all residents have a clear and legible medication record with up-to-date resident data to ensure safe practice.

• All invalid MAR charts have been replaced with legible, prescriber-signed records, and a full review of medications has been completed by pharmacist. Expired and discontinued medications have been removed, and all relevant medications are now dated on opening.

• Medication administration practices have been standardised and strictly controlled. Medications are administered one resident at a time, at the point of care, with no pre-signing of MARs and no pre-preparation of medications. Medication trolleys are secured at all times, never left unattended, and keys are held by the nurse.

• Medication management is monitored through governance systems, with weekly review of audits and KPIs to ensure sustained compliance with Regulation 29 and NMBI standards.

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:

All residents' care plans have been fully reviewed and updated by Named Nurses and Clinical Nurse Managers to ensure they are based on current assessments and reflect residents' needs, preferences, and capacities.
All nutritional care plans have been updated by COM/PIC to reflect current recommendations from health professionals, including correct food and fluid consistencies.
The PIC and COM have reviewed the skin integrity care plans to reflect up to date information in relation to Repositioning ,plan of care and TVN recommendations .All historical data will be removed to ensure clarity .The CNMs will supervise care plans daily and refer to TVN .Any new risks will be reported by the CNM to the PIC.
A Serious Incident Review of wounds and skin injuries from the 1st September 2025 will be carried out by the Clinical Operations Manager ("COM") in conjunction with the Tissue Viability Nurse ("TVN"). Learning from this review will be implemented immediately by the DON (PIC) with oversight by the COM. All residents will have their skin integrity comprehensively assessed with a visual check by the senior clinical team. These assessments will be split between the COM, the DON (PIC), the ADON and the CNMs. TVN will have an input into these assessments as appropriate. High risk residents will be identified and prioritised for intervention.
All care plans now include individualised personal needs and preferences, ensuring person-centred care delivery.
Daily supervision by CNMs ensures care plans are updated following any change in condition or MDT review.
Staff are required to use care plans as the primary guide for care delivery, and compliance is monitored through supervision and audit. Any deficits are addressed immediately through supervision and retraining.
The care plan will be communicated to staff, and it will guide them in care delivery. The care plan will address the following:

1) Identify what equipment is required. Pressure relieving equipment will be checked that it is operating correctly and is in use.

2) Seek a review by a dietician as appropriate and their recommendations will be followed. Residents will be weighed monthly and weekly if necessary. Mealtimes will be supervised to ensure that residents are receiving an adequate nutritional intake.

3) Turning and repositioning of residents. Spot checks will be carried out on turning and repositioning schedules and manual handling practices by the COM, the DON (PIC), the ADON and the CNMs. The checks will include nighttime and early morning checks.

4) Skin integrity inspections to be carried out during personal care. Spot checks will be carried out on the skin inspections by the COM, the DON (PIC), the ADON and the CNMs.

5) Spot checks to be carried out on personal hygiene and skin care practices to ensure

that skin integrity is maintained by proper cleaning after incontinence, use of barrier cream and moisturising to prevent dryness. The spot checks will be carried out by the COM, the DON (PIC), the ADON and the CNM.

Regulation 6: Health care	Not Compliant

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

All residents' assessments and care documentation have been reviewed and updated to ensure they reflect current needs and are aligned with evidence-based practice and professional guidelines issued by An Bord Altranais agus Cnáimhseachais. Audit system and daily CNM supervision are in place to ensure documentation is accurate, complete, and guides care delivery.
Medication management practices have been standardised, supervised, and audited, ensuring safe administration in line with professional standards. Nursing competency is assessed through training and supervised practice, and staff who have not demonstrated competence do not practice unsupervised.
A structured referral pathway has been implemented to ensure residents' needs for additional expertise are recognised and acted upon promptly. Nursing staff are required to identify changes in residents' condition and escalate appropriately, with timely referral to relevant professionals (e.g. GP, Tissue Viability, SALT, Dietitian).
All referrals and recommendations from the multidisciplinary team (MDT) are documented, implemented, and reviewed, with oversight by the CNM and Person in Charge.
Compliance is monitored through audit, supervision, and governance review, ensuring that residents receive timely access to appropriate healthcare and consistent, high-quality nursing care.

Medication Management:

Online medication training has been delivered to the nurses. Additional classroom-based medication training was delivered on the 26th March 2026. The COM, the DON (PIC), the ADON and the CNMs will work with the staff nurses to support them, to supervise their practice and to make them aware of their responsibilities under the professional guidelines issued by the Nursing and Midwifery Board of Ireland. They will conduct spot checks and carry out medication round audits with the staff nurses. Feedback and learning from this will help to improve practice.

The COM conducted an observational audit of the medication practices post inspection, and the findings were recorded. These findings and recommendations were discussed with the PIC and nurses, to ensure a safe medication administration practice.

The Practice Development Nurse will commence in post and will carry out medication round audits with the staff nurses to improve practice.

Pressure Area Care:

All residents will have their skin integrity comprehensively assessed with a visual check by the senior clinical team. These assessments will be split between the COM, the DON (PIC), the ADON and the CNMs. TVN will have an input into these assessments as appropriate. High risk residents will be identified and prioritised for intervention.

The DON (PIC) will arrange for a care plan to be prepared/reviewed based upon these assessments. The care plan will be communicated to staff, and it will guide them in care delivery. The care plan will address the following:

1) Identify what equipment is required. Pressure relieving equipment will be checked that it is operating correctly and is in use.

2) Seek a review by a dietician as appropriate and their recommendations will be followed. Residents will be weighed monthly and weekly if necessary. Mealtimes will be supervised to ensure that residents are receiving an adequate nutritional intake.

3) Turning and repositioning of residents. Spot checks will be carried out on turning and repositioning schedules and manual handling practices by the COM, the DON (PIC), the ADON and the CNMs. The checks will include nighttime and early morning checks.

4) Skin integrity inspections to be carried out during personal care. Spot checks will be carried out on the skin inspections by the COM, the DON (PIC), the ADON and the CNMs.

5) Spot checks to be carried out on personal hygiene and skin care practices to ensure that skin integrity is maintained by proper cleaning after incontinence, use of barrier cream and moisturising to prevent dryness. The spot checks will be carried out by the COM, the DON (PIC), the ADON and the CNMs.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
An additional Activities staff member has been recruited, and activity hours have increased by two hours daily. The activities programme has been reviewed and restructured, with a focus on inclusive, person-centred engagement across communal areas and bedrooms.
All residents have individualised activity assessments and care plans, which guide staff in delivering meaningful, preference-based activities, including one-to-one engagement for residents in their bedrooms.
Supervision arrangements have been strengthened, with the Activities Coordinator overseeing delivery, and CNMs and the PIC providing daily oversight to ensure residents are offered and supported to participate in activities.
A system of daily monitoring and weekly review of activity provision and resident participation is in place. Any gaps are identified and addressed promptly through staff reallocation and programme adjustment.
Initiatives implemented include:
• Structured one-to-one activity provision (including use of activity resources for room visits)
• Fresh air and outdoor access, supported by allocated staff
• Guidance tools for staff to support engagement with high-dependency residents
Residents' choice, dignity, and preferences are promoted at all times, including during mealtimes. Medication administration practices have been revised to ensure mealtimes are protected and not disrupted.

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	15/04/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Red	31/03/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	31/03/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	03/04/2026

Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Red	17/02/2026
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	03/04/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	20/04/2026
Regulation 24(2)(a)	The agreement referred to in paragraph (1) shall relate to the care	Substantially Compliant	Yellow	03/04/2026

	and welfare of the resident in the designated centre concerned and include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.			
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.	Substantially Compliant	Yellow	03/04/2026
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Red	30/03/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in	Not Compliant	Orange	03/04/2026

	charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.	Not Compliant	Orange	03/04/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	03/04/2026
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	03/04/2026
Regulation 5(3)	The person in charge shall	Not Compliant	Orange	03/04/2026

	prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
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	03/04/2026
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	03/04/2026

Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Orange	03/04/2026
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	03/04/2026
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	03/04/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	03/04/2026