



**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:	Ennistymon Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Dough, Ennistymon, Clare
Type of inspection:	Unannounced
Date of inspection:	23 January 2026
Centre ID:	OSV-0000608
Fieldwork ID:	MON-0046895

About the designated centre

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

Ennistymon Community Hospital is operated by the Health Service Executive (HSE). The building is situated in a rural setting close to the town of Ennistymon. The centre can accommodate 31 residents. The service provides 24-hour nursing care to both male and female residents. Long-term care, short stay and palliative care is provided, mainly to older adults. Bedroom accommodation is provided in single, twin and four bedded rooms. All bedrooms have en suite shower and toilet facilities. There is a variety of communal day spaces available to residents including day room, dining room, front conservatory, visitors room, oratory, historical area and memory lane village. Residents have access to an enclosed garden courtyard area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21
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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
Friday 23 January 2026	09:30hrs to 17:30hrs	Leanne Crowe	Lead
Friday 23 January 2026	09:30hrs to 17:30hrs	Sharon Kane	Support

What residents told us and what inspectors observed

Overall, the inspectors observed that residents living in Ennistymon Community Hospital received person-centred care, and were supported to enjoy a good quality of life.

Ennistymon Community Hospital is a two-storey building, located outside Ennistymon in Co. Clare. The centre can accommodate up to 31 residents, in single and multi-occupancy bedrooms. On the day of the inspection, 21 residents were living in the centre.

This was an unannounced inspection, carried out over one day. On arrival to the centre, the inspectors were greeted by a Clinical Nurse Manager (CNM), who was deputising for the person in charge. A person participating in the management of the centre (PPIM) was also in attendance, to facilitate the inspection. Inspectors completed a walk around the centre, observing that many residents were being assisted with their morning care. Residents confirmed to inspectors that staff were aware of, and respected, their individual routines and personal preferences.

The centre was warm, bright and visibly clean throughout. However, it was noted that some aspects of the premises were not well-maintained, such as some areas of flooring, and surfaces of walls, doors and skirting boards. A number of communal rooms were available, including a day room, a dining room, a conservatory, a parlour and a chapel. Inspectors observed that the parlour and visitors' room had been decluttered since the previous inspection and were now available for use. Residents' bedrooms were found to be suitably furnished and well-decorated with personal items such as photographs, plants and soft furnishings.

Overall, there was a calm atmosphere in the centre throughout the day of the inspection. Staff were observed to promptly attend to residents, while also interacting in a kind and respectful manner. For example, staff requested permission prior to providing care or knocked on bedroom doors prior to entering the room. Residents who spoke with inspectors stated that they were happy with the staffing complement and the care provided to them. They described the staff team as "excellent", "kind" and "patient".

Residents' civil and political rights were supported. For example, residents were facilitated to vote in the recent presidential election, either in the nursing home or in their local constituency.

Residents stated that they could choose how they spent their day. For example, one resident described how they liked to get up early, have breakfast brought to their room, and spend time saying their prayers in their room before attending Mass in

the day room at 11am. Inspectors observed staff supporting the resident with this routine on the day of inspection.

A programme of activities was available to residents, with the majority of these occurring in the centre's day room. The schedule for activities was displayed in a number of places throughout the centre, and residents who spoke with inspectors were aware of the upcoming schedule. A staff member was allocated to the provision of activities and supervision of residents in the day room, and was observed actively engaging with residents throughout the day. Many residents participated in a number of activities, including an exercise class, board games and painting. Residents told inspectors that "there was plenty of activities happening during the day" and "you wouldn't be stuck for something to do".

Inspectors observed the lunch service in the dining room. Music was playing softly throughout the meal. The food served to residents was freshly prepared, and residents appeared to enjoy their meals. Residents spoken with confirmed that they had a choice of meals and stated that food "was very good, as good as any hotel". Another resident joked that her only complaint was that there "was too much food". Several residents required assistance with their meals, and this was provided in a discreet manner. A number of residents received their meals in their bedrooms, as was their choice. One resident told inspectors that she preferred to have her meal in private, and that this was always facilitated by staff.

Residents could receive visitors in the centre within communal areas, a visitors' room, or in the privacy of their bedrooms. Multiple families and friends were observed visiting their loved ones throughout the day of the inspection.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements that were in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered to residents.

Capacity and capability

The findings of this inspection were that the residents received a good standard of care. The provider had sufficient resources to effectively deliver this care to residents.

This was a one day 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 (as amended). Inspectors followed up on the provider's compliance plan response to the previous inspection in February 2025, and found that all actions had been completed. Inspectors also followed up on solicited and unsolicited information received by the Chief Inspector since the last inspection. This

information was found to be substantiated, and the provider had already put measures in place to address the concerns raised.

This inspection found that Regulation 16, Training and staff development, Regulation 19, Directory of residents and Regulation 17, Premises, were not fully aligned with the requirements of the regulations.

The registered provider is the Health Service Executive (HSE). There was a clearly defined management structure in place, with identified lines of authority and accountability. A member of senior management participated in the management of the centre. The person in charge worked full-time in the centre. They were supported in this role by two CNMs, as well as a team of nurses, multi-task attendants, catering, housekeeping, maintenance and administrative staff.

There were management systems in place to monitor and review the quality of the service provided to residents. Clinical and environmental audits were completed which included reviews of care planning, medicines management, and infection control. Where areas for improvement were identified, action plans were developed and completed. The provider also monitored quality of care indicators such as pressure ulcers, complaints, falls, and the use of restrictive practices, to identify any trends or areas of improvement. An annual review of the quality and safety of care in 2025 had been drafted at the time of this inspection.

Meeting records reviewed demonstrated that the nursing management team met on a regular basis, and that the person in charge also attended management meetings at a regional level.

Since the previous inspection, the provider had successfully recruited a significant number of staff to fill existing vacancies in nursing and care assistant roles. This had addressed the non-compliances identified on the last inspection in relation to the provider's management of resources, and had positively impacted on the quality of the service being provided to residents. On this inspection, the staffing levels and skill mix were observed to be appropriate to meet the assessed health and social care need of the residents accommodated in the centre. Residents who spoke with inspectors felt that there were sufficient staff on duty to provide assistance, when needed.

A review of the training records for staff found that training was not up-to-date in a number of areas, including safeguarding and moving and handling practices. In addition, a number of recently recruited staff had not yet received fire safety training, therefore the provider could not ensure that all staff were sufficiently knowledgeable of fire safety procedures. At the time of the inspection, the provider had placed measures in place to mitigate this risk while staff completed fire safety training in the weeks following the inspection.

The centre had a complaints policy and procedure which described the process of raising a complaint or a concern. A record of complaints was maintained by the person in charge. While only a small number of complaints had been recorded, the records reviewed demonstrated that complaints were investigated and resolved, in line with the regulations. The provider had recently completed a review of

complaints management within the centre, and had identified areas of improvement. An action plan had been developed and was in progress at the time of the inspection.

The registered provider maintained a directory of residents in the centre; information within this directory was incomplete, and not in line with the requirements of the regulations.

Regulation 15: Staffing

On the day of the inspection, the number and skill mix of staff was appropriate with regard to the needs of the residents, and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of training records indicated that seven staff did not have up-to-date training in fire safety, three staff did not have up-to-date training in safeguarding procedures and five staff did not have up-to-date training in moving and handling practices.

Judgment: Substantially compliant

Regulation 19: Directory of residents

While the registered provider maintained a directory of residents, it did not contain all of the information required by Schedule 3 of the regulations. For example, the details of a resident's GP and the details of a resident's next of kin, or person authorised to act of a resident's behalf were not always recorded.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The management team were aware of their individual lines of authority and accountability.

There were sufficient resources available to ensure the delivery of care in accordance with the centre's statement of purpose.

The systems in place ensured that the service provided was effectively monitored.

Judgment: Compliant

Regulation 24: Contract for the provision of services

The inspector reviewed a sample of residents' contracts of care. Each contract outlined the terms and conditions of the accommodation and the fees to be paid by the resident. All contracts had been signed by the resident and/or their representative.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaints log found that complaints were managed and responded to, in line with the regulatory requirements.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the management and staff worked to provide a good quality of life for the residents living in the centre. Residents' wellbeing and independence were promoted. Residents reported that they were satisfied with the service they received and told inspectors that they felt happy living in the centre.

Inspectors reviewed a sample of residents' files. Residents had an assessment completed prior to admission, and a range of validated assessment tools was used to assess care needs. The outcomes of these assessments were used to develop a care plan for each resident, addressing their individual abilities and assessed needs. The care plans reviewed contained the necessary information to guide care delivery. Care plans were reviewed every four months, or in response to changes in residents'

assessed needs, in line with regulatory requirements. Residents and their families, where appropriate, were involved in the care planning process.

A review of residents' records found that residents had access to a general practitioner (GP), as requested or required. There was a referral system in place to a range of allied health professionals, including physiotherapists, occupational therapists, and palliative care services. From the sample of documentation reviewed, it was evidenced that recommendations from allied health professionals were implemented by staff.

The centre promoted a restraint-free environment, whereby there was appropriate oversight and monitoring of restrictive practices. Restrictive practices were only initiated following an appropriate risk assessment, and in consultation with the resident or their nominated representative, where applicable. There was evidence that the use of restrictive practices were reviewed regularly.

There were systems in place to support residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express physical discomfort, or discomfort with their social or physical environment). These care plans were person-centred and provided guidance to staff on how to support residents who exhibited such behaviours. Staff spoken with on the day of inspection demonstrated knowledge residents' individual triggers and de-escalation strategies.

There were systems in place to safeguard residents. There was a policy and procedure in place to guide staff in the investigation of any allegations of abuse. The majority of staff had up-to-date training in safeguarding procedures.

There was an activity schedule in place, and residents were observed to be supported with social engagement and appropriate activities throughout the day. Significant improvements had been made to the variety and quality of activities since the previous inspection, as well as the allocation of staff to support the provision of social care. Residents reported that they had plenty to do during the day, and inspectors observed residents participating in activities throughout the inspection.

Residents' rights and choices were respected and upheld, and their independence was promoted. Residents had opportunities to meet together and discuss management issues within the centre. Residents also had access to an independent advocacy service.

The premises was well laid out to meet the needs of residents. Two communal rooms being used as storage rooms on the last inspection were now free of equipment and were available for residents to use. The centre was visibly clean and tidy on the day of the inspection, however, some areas in the older part of the centre were found to be in a poor state of repair. For example, damaged flooring, paint peeling on walls and ceilings, and scuff marks to areas of high traffic.

Regulation 11: Visits

The registered provider had suitable arrangements in place for residents to receive visitors. There was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 17: Premises

Some floor coverings and surfaces did not meet the requirements of Schedule 6 of the regulations, as they were not in a good state of repair. This included flooring, surfaces of walls and skirting boards.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents' needs were assessed within 48 hours of admission to the centre, and regularly thereafter. The assessments were used to inform the development of care plans, which reflected the residents' respective needs. Care plans were reviewed every four months, or more frequently if required.

Judgment: Compliant

Regulation 6: Health care

Residents had access to appropriate medical care including a GP and a range of allied health care professionals such as physiotherapy, occupational therapy and palliative care services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A restraint-free environment was supported in the centre. Residents who experienced responsive behaviours were observed to receive care and support from

staff that was person-centred, respectful, and non-restrictive. Staff had up-to-date knowledge to support residents to manage their responsive behaviours.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse.

At the time of this inspection, the provider did not act as a pension agent for any residents living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were upheld in the designated centre. The inspectors observed that residents' privacy and dignity were respected by staff. There was a schedule of activities provided for residents.

Residents' meetings occurred bimonthly, and records indicated that residents had been consulted and had opportunities to participate in the organisation of the centre. Advocacy services were available to residents as needed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ennistymon Community Hospital OSV-0000608

Inspection ID: MON-0046895

Date of inspection: 23/01/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Following the inspection, the centre took immediate action to address the training deficits identified.</p> <ul style="list-style-type: none"> • On 24 February 2026, 18 staff members completed Fire Safety Training. • By the 13th March 2026, all staff had completed Safeguarding Training. • By the 28th of April 2026, all Moving and Handling Training will be completed.. • All newly recruited staff will complete mandatory training—including fire safety, safeguarding, and moving & handling—prior to working without supervision. • The PIC will review the training matrix weekly to ensure ongoing compliance and early identification of any gaps. • Additional training has been scheduled, including Positive Behaviour Support, A Human Rights Based Approach to Restraint/Restrictive Practice Reduction, and Falls Management. • The centre remains committed to maintaining all mandatory training in line with regulatory requirements. • The Person in Charge will continue to monitor training records to ensure training remains up to date, and that any future shortfalls are addressed promptly and proactively. 	
Regulation 19: Directory of residents	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 19: Directory of residents:</p>	

Following the inspection, a review of the Directory of Residents was undertaken to ensure full compliance with Schedule 3 of the regulations. As of the 27th of February 2026, the Directory of Residents has been updated to include all required information, including details of each resident's general practitioner (GP), Next of Kin (NOK) and any person authorised to act on the resident's behalf. The Person in Charge will continue to monitor the Directory of residents so that the required information remains complete, accurate and up to date.

Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider acknowledges the areas requiring improvement in relation to the premises and has put in place a structured plan to address all outstanding works. The following actions will ensure full compliance with the National Standards for Residential Care Settings for Older People in Ireland and the relevant Older Persons Regulations.

1. Flooring Replacement – Older Section of the Building

Issue: Flooring in the older part of the building is worn, uneven in places, and no longer meets best practice standards for infection prevention and resident safety.

Actions:

- Specification Development:
 - Complete a detailed assessment of all affected flooring areas.
 - Prepare a written technical specification outlining materials, slip resistance requirements, infection control features, and durability standards.
- Procurement:
 - Seek a minimum of three quotes from qualified contractors on the HSE-approved panels.
 - Review quotes for cost, compliance with specification, and capacity to deliver works with minimal service disruption.
- Implementation:
 - Schedule the flooring works in phases to ensure resident safety and continuity of service.
- Timeline:
 - Completion by end of Q3 2026.

2. Painting Works – Old Part of the Building

Issue: Internal paintwork in the Older section of the building requires refreshing to maintain quality, hygiene and regulatory compliance.

Actions:

- Develop a painting specification (colour scheme, infection control suitable paints, low VOC materials).
- Obtain three quotes and select contractor.
- Plan works during Around resident activity.
- Timeline:

Completion by Q3 2026.

3. Redecoration of the 'Good Room'

Issue: The 'good room' used for family visits and social occasions needs refreshing and does not meet the expected standard of a dementia friendly, homely environment.

Actions:

- Agree design brief with residents, families, and staff.
- Update soft furnishings, lighting, flooring, colour scheme and furniture.
- Ensure compliance with dementia friendly environmental guidelines.
- Timeline:

Works completed in parallel with painting programme, by Q3 2026.

4. Repair of Floors – New Part of Building

Issue: Identified areas in the new building require floor repairs due to surface defects.

Actions:

- Survey and document defective areas.
- Include repairs in the flooring specification package.
- Contractors to address these repairs concurrently with the older-building works.
- Timeline:

Completed by Q3 2026.

5. Restoration of 'Memory Lane' – Engagement with Local Artist

Issue: 'Memory Lane' requires restoration to its original specification to maintain its therapeutic and dementia friendly purpose.

Actions:

- Formal engagement with the local artist who created Memory Lane.
- Develop a scope of works outlining artwork refresh, repair and colour restoration.
- Ensure materials chosen are durable, wipe clean and safe for clinical settings.
- Schedule works to avoid resident disruption.
- Timeline:

Restoration completed by Q3 2026.

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Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2026
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	27/02/2026