Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Sonas Nursing Home Carrick-on-Suir
Name of provider:	Sonas Asset Holdings Limited
Address of centre:	Waterford Road, Carrick-on-Suir, Tipperary
Type of inspection:	Unannounced
Date of inspection:	05 March 2026
Centre ID:	OSV-0007883
Fieldwork ID:	MON-0049513

About the designated centre

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

Sonas Nursing Home Carrick-on Suir is located a five minute walk from the town centre and serves the local community of approximately 12,000 people. The nursing home is a purpose-built care home that provides accommodation for 55 residents in mostly single-bed accommodation with some twin rooms available. There are two internal landscaped courtyards with outdoor seating provided. Bedroom accommodation provides bright en-suite rooms with built-in safety features such as a call-bell system, fire doors with safety closures, wheelchair accessible bathrooms, grab-rails, profiling beds, television and private telephone line. There are two open plan living rooms, a family room and an oratory. Care and services are provide to both male and female residents over the age of 65 and those under 65 may be accommodated, if the centre can meet their assessed needs. Residents with low to maximum dependencies can be accommodated. Nursing care is provided to residents who require long-term care, convalescent, respite or palliative care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	53

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 5 March 2026	09:20hrs to 18:00hrs	Leanne Crowe	Lead
Thursday 12 March 2026	10:30hrs to 17:00hrs	Leanne Crowe	Lead
Thursday 5 March 2026	09:20hrs to 18:00hrs	Catherine Sweeney	Support
Thursday 12 March 2026	10:30hrs to 17:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

This inspection took place over two days, during which inspectors spoke with a large number of residents and visitors. The feedback regarding their experience of Sonas Nursing Home Carrick-on-Suir was mixed. While some residents and visitors were complimentary about the care, the majority of residents and relatives spoken with were dissatisfied with the overall quality of the service provided.

Inspectors walked through the centre and spent time talking with residents and staff, observing the care provided to residents, and the care environment.

While inspectors observed staff being kind and courteous towards residents, care was not always delivered to a high standard, or in a timely manner. Inspectors observed instances on both days of the inspection where there were delays in staff responding to residents' call bells. Additionally, inspectors observed residents calling out for assistance, with no access to their call bell, on a number of occasions throughout the inspection. Inspectors noted that in some of these bedrooms, call bells were not within reach of the residents. Furthermore, while there were staff allocated to supervise communal areas and provide assistance to residents in these areas, inspectors noted that staff did not always use these opportunity to converse or engage with residents. A large number of residents spoke with inspectors, and while some acknowledged that staff could be busy and "were trying their best", most expressed dissatisfaction with the delays they experienced in receiving care or assistance.

Friends and families were facilitated to visit residents, and inspectors observed many visitors coming and going throughout both days of the inspection. Inspectors spoke with a number of visitors who were generally satisfied with the care provided to their loved ones. However, some visitors expressed their dissatisfaction with some aspects of the service, included concerns about staffing levels and staff turnover, management of laundry, the quality of the care provided to their loved ones, and the length of time taken to respond to call-bells or requests for assistance. Some visitors highlighted that while they had raised concerns with staff, they did not always feel that these concerns were listened to or were being appropriately addressed. One visitor advised that they had raised a complaint with staff but had not received a response regarding this.

Inspectors observed that the care environment was not maintained to an acceptable standard of cleanliness. Floors appeared visibly unclean and there was significant malodour throughout the centre. Following an urgent compliance request to clean the centre, there was some improvement noted on the second day of the inspection. On both days of the inspection there was only one cleaner on duty to clean the centre.

On day one of the inspection, while there was a member of staff allocated to the provision of activities, the only activity on offer was attendance to the hairdresser. Residents were observed spending extended periods of time sitting in the day room, watching television, with minimal social engagement.

The following sections of this report details the findings with regard to the capacity and management of the centre, and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced inspection carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also reviewed unsolicited information received by the Chief Inspector relating to concerns regarding governance and management of the centre, staffing levels, training and development, management of complaints and the quality of personal care provided to residents. This information was found to be substantiated on this inspection.

Sonas Asset Holdings Limited was the registered provider for Sonas Nursing Home Carrick-on-Suir. A company director represented the registered provider entity. A member of the executive management team participated in the management of the centre. A regional manager was in place to support the person in change and to provide oversight of the service. The person in charge worked in the centre on a full-time basis and was supported in their role by a clinical nurse manager (CNM), nursing staff, health care assistants, a physiotherapist, catering, housekeeping, activities staff and maintenance staff. The position of assistant director of nursing was vacant, and one clinical nurse manager was on planned leave, at the time of the inspection.

This inspection was scheduled to take place over one day. However, due to significant non-compliances identified on the first day of the inspection in relation to Regulation 15: Staffing, and Regulation 26: Infection control, a request for immediate action was issued to the provider to address the cleanliness of the centre. A second day of inspection was carried out to follow up on the action taken by the provider to address these risks. Inspectors again found that these identified risks had not been adequately addressed by the registered provider. Consequently, an urgent compliance plan request was then issued to the provider, seeking assurances in relation to staffing resources, information governance, and the systems of management. The urgent compliance plan submitted by the provider was accepted by the Chief Inspector.

The findings of this inspection were that the registered provider had failed to ensure that there were sufficient resources in place to effectively deliver care to residents or

to maintain an acceptable standard of environmental hygiene. In addition, the organisation and management of staffing resources was not effective, and this had adversely impacted the quality of the service provided.

On the first day of inspection, inspectors found that staffing arrangements, particularly in housekeeping, were inadequate and poorly managed. Inspectors found that there had been insufficient housekeeping staff on duty for several weeks prior to the inspection, which resulted in the centre being visibly unclean and malodorous. While these deficits in staffing levels had been escalated to the senior management at weekly management meetings, there was no evidence of additional resources being provided to address this deficit. As a result, immediate action was required from the provider to address the cleanliness of the centre. The provider's response was to reallocate staff from other departments within the centre to housekeeping duties.

This inadequate oversight of staffing resources extended to the nurse management structure within the centre. There were insufficient staffing arrangements in place to ensure planned and unplanned leave could be covered. For example, the centre's staffing requirements, as outlined in the centre's statement of purpose, included two clinical nurse managers to support the person in charge to supervise the delivery of care. However, on the first day of inspection, one clinical nurse manager was on unplanned leave, and no replacement was available, while the second clinical nurse manager was on planned leave and no arrangements had been made to cover this absence. The impact of the failure to ensure appropriate management oversight resulted in a sub-standard quality of resident care, inadequate supervision of staff, a deterioration in the quality of the care environment, and a negative impact on the the quality of residents' lives. By day two of the inspection, the registered provider had rostered additional supervisory staff to oversee the delivery and quality of care within the service.

A second day of inspection was carried out to follow up on the provider's response to address deficits in quality of environmental hygiene and to assess whether sufficient and sustained improvements had been implemented. Inspectors found that, while some immediate actions had been taken, these actions had not been sustained. On the day of the inspection, an unplanned staff absence resulted in only one staff member being responsible for housekeeping duties, and there were insufficient resources available to cover this absence. This issue had not been identified by the management team in the centre on the day of the inspection. Inspectors were informed by the nurse management team that staff had been reallocated from the delivery of care to residents, to housekeeping duties, consequently reducing the number of care assistants available to provide direct care to residents from ten staff to eight staff. There was no evidence that this reallocation of resources was informed by a comprehensive analysis of residents' needs and dependencies, or that an appropriate number and skill-mix of staff remained to deliver a high standard of care to residents.

The management structure in the centre did not clearly identify the lines of authority and accountability. Members of the management team could not outline key individual roles and responsibilities. While there was a number of appropriate

communication systems in place in the centre, such as weekly governance meetings, and monthly meetings with a quality manager, the processes for communicating and escalating identified risks were not clearly defined, and not effective to ensure that risks were escalated in a timely manner. For example, the nurse management team told inspectors that they were aware that not all staff, who were subject to professional registration, had current registration details on file. Despite this, one staff member was rostered to perform duties, unsupervised, without a professional registration remit. There was no evidence that this issue was identified and escalated to the provider as a potential risk to residents.

The management systems in place to monitor the quality and safety of care were not effective. These governance deficits had a significant impact on residents' safety and the quality of care provided to residents. This was evidenced by:

- Inadequate oversight of nursing care and nursing documentation. For example, assessments and care plans were incomplete or were not developed in consultation with residents.
- Inadequate oversight of staffing allocation and supervision, evidenced by inadequate levels of housekeeping staff
- Poor oversight of record management, including assurances required in relation to staff records
- Inadequate information governance, for example; the use of first names for digital signatures on nursing records and on staff rosters.
- While there was a schedule of clinical and environmental auditing in place, the auditing programme did not always ensure that issues of risk identified were addressed. Inspectors found that some recent audits carried out by the management team did not reflect issues in relation to environmental hygiene such as the poor standard of cleanliness in the centre, and therefore no quality improvement plan was developed. In addition, while action plans were developed in response to other audit findings, a review found that these were not always completed. Furthermore, despite having received complaints from residents and visitors in relation to delays in answering call bells, there was no oversight or auditing of call bell response times by the nurse management team.

Inspectors found that the management of records was not in line with the requirements of the regulations. Nursing documentation did not reflect an accurate and person-centred record of a resident’s health and condition and treatment given, completed on a daily basis, in accordance with professional guidelines, as required by Schedule 3(4)(c) of the regulations. In addition, the staff roster was not consistently updated to reflect absence.

Furthermore, Inspectors found that the provider had not ensured that there was a record of current registration details of all professional staff who were subject to registration, as required by the regulations. Immediate action was required by the provider to address this risk.

A review of the system of complaints management found that complaints were not managed in line with the centre's own complaints management policy or the requirements of Regulation 34: Complaints.

Regulation 15: Staffing

The registered provider had failed to ensure that there were sufficient staffing levels in the centre to meet the assessed needs of the residents, or for the size and layout of the centre. For example;

- residents waiting extended periods of time for assistance
- inadequate levels of cleaning staff to ensure an appropriate level of environmental hygiene
- inadequate level of senior nursing staff to ensure appropriate supervision of care.

An urgent compliance plan was issued to the registered provider following this inspection. This urgent plan was accepted by the Chief Inspector.

Judgment: Not compliant

Regulation 16: Training and staff development

The arrangements in place to supervise staff were not appropriate. This was evidenced by;

- The allocation of staff throughout the two days of the inspection did not ensure that residents' needs were met in an appropriate and timely manner.
- Poor oversight and supervision of cleaning duties.
- Inadequate oversight of nursing documentation

Judgment: Not compliant

Regulation 21: Records

Management of records was not fully in line with regulatory requirements. For example,

- staff files reviewed showed that the registered provider had failed to ensure that appropriate documentation was obtained for each staff member, as per Schedule 2 requirements

- the staff roster had not been updated to reflect changes, and was therefore not accurate
- the daily records for residents were not documented in a manner that described residents' health and condition.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. This was evidenced by;

- the management structure had not been maintained in line with the centre's statement of purpose. Nurse managers were absent due to planned and unplanned leave, with no contingency arrangements implemented to maintain effective supervision and governance of the service.
- there were insufficient resources to maintain an acceptable standard of environmental hygiene in the centre on both days of the inspection. Following the first day of the inspection, the reallocation of staff to address this deficit consequently reduced the resources dedicated to care provision.

The provider had failed to put in place a clearly defined management structure that effectively identified lines of authority and accountability, specified roles, and detailed responsibilities for all areas of care provision. This was evidence by the failure to appropriately identify, manage and escalate issues of risk.

The registered provider had failed to ensure there were effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- Ineffective systems to ensure key clinical information regarding residents care needs were effectively communicated to staff. Staff did not have access to accurate information about residents' individual medical and nursing care needs, which significantly impacted the quality and safety of care provided.
- The systems in place to supervise staff and staff practice was inadequate.
- The systems in place to monitor, evaluate and improve the quality of the service were not effective in identifying deficits and risks in the service. For example, there was a lack of robust auditing and monitoring of the care environment and the quality of the cleaning processes. This meant that risks and deficits in the quality and safety of the service were not identified or subject to quality improvement action plans.

An urgent compliance plan was issued to the registered provider following this inspection. This urgent plan was accepted by the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the records found that complaints were not recorded, managed and responded to, in line with the regulatory requirements. This was evidenced by a number of complaints that were not investigated, and therefore no cause, or opportunity for learning had been established. Furthermore, complainants were not contacted and informed in relation to the management and outcome of their complaint.

Judgment: Not compliant

Quality and safety

The quality and safety of care provided to residents was compromised as a result of ineffective systems of governance and management described in the capacity and capability section of this report.

Inspectors found that the standard of environmental hygiene and cleanliness within the centre was poor. This was evidenced by unclean conditions in a number of areas used by residents and staff, and by cleaning practices that were not effective in maintaining an acceptable standard of hygiene throughout the day.

Residents' care plans and daily nursing notes were recorded through an electronic record system. A sample of residents' assessments and care plans were reviewed and found that, while all residents had a care plan in place, the plans were not always informed by a comprehensive or accurate assessment of their care needs. This was particularly evident in the management of nutritional risk. A sample of care plans reviewed did not contain up-to-date interventions required to meet residents current needs in a person-centered manner.

Residents who refused care did not have alternatives care interventions considered, and care plans were not updated to reflect refusal of care in order to guide staff to meet the needs of the residents. Care plans also reflected a poor awareness in relation to the Capacity Act 2015 (as amended) and a residents' right to self-determination.

Residents' health care needs were supported by access to general practitioner services (GP), when required or requested. There were arrangements in place for residents to be referred to allied health professionals, through appropriate care pathways where required, including access to dietetic services, tissue viability

nursing expertise, and physiotherapy. However, some residents, assessed as requiring psychological support did not have an appropriate care plan, or referral pathway for specialised care. In addition, nursing documentation was not in line with professional guidelines.

Residents were not provided with adequate opportunity for activities. Residents were observed to spend extended periods of time in the day rooms without any facilitation of social engagement.

Regulation 27: Infection control

The designated centre was visibly unclean on the days of the inspection posing an infection control risk to residents. This was due to

- inadequate cleaning schedule and resources available
- inadequate supervision and oversight of cleaning.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Individual assessments and care plans were not in line with the requirements of the regulations. Some residents did not have a comprehensive assessment of their needs completed. For example,

- a resident with a reduced dietary intake did not have an up-to-date assessment of nutritional risk completed. Consequently, there was no appropriate care plan developed to guide the delivery of care.
- nursing assessments in relation to skin integrity had not been updated and reviewed following changes to nutritional assessments.

Care plans were not developed from appropriate assessments. Interventions for some end of life care plans were awaiting the residents' relatives approval, and had not been developed, discussed or agreed with the residents themselves.

Judgment: Not compliant

Regulation 6: Health care

Medical and health care was not always delivered or documented to residents to a high standard, in accordance with professional guidelines. This was evidenced by;

- residents assessed as requiring psychological support did not have appropriate assessment or referral for required needs
- incomplete and inadequate nursing documentation

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' rights were not fully upheld in the centre.

Residents were not provided with opportunities to participate in activities in accordance with their interests and capacities. For example, on the first day of the inspection, the only activity on offer in the morning was a visit to the hairdresser. A member of staff who was allocated to provide activities to all residents, spent the morning facilitating visits to the hair salon. There was no alternative activity organised for residents who were not attending the hairdresser.

Residents were not always consulted in relation to interventions relating to their care.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 27: Infection control	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 Sonas Nursing Home Carrick-on-Suir OSV-0007883

Inspection ID: MON-0049513

Date of inspection: 12/03/2026

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:

Following the inspection, a full review of staffing levels, skill mix and resident dependency was completed by the Provider, Chief Clinical Officer (CCO), Quality Manager (QM), Person in Charge (PIC) and Director of HR using a validated dependency assessment tool to ensure staffing levels reflected residents assessed needs and the size and layout of the centre. Additional reviews have been ongoing prior to the issuing of each roster.

Immediately after the inspection, in order to address the housekeeping staffing deficit, a deep clean of the centre was completed by an external cleaning company.

Housekeeping staffing levels were then immediately restored to ensure:

- A minimum of two housekeeping staff are rostered daily.
- Additional contingency cover is available for planned and unplanned absences.

Clinical Management hours were reviewed and an additional 10 hours per week were added to the roster in order to support the additional work which was now required in terms of oversight, clinical supervision and training and development. This brought the total number of supernumerary management hours to 50 per week. These hours are supplied by the CNM 1, CNM 2 and the SSN.

The deputising and on-call roster was reviewed and strengthened by QM and CCO involvement and oversight.

The CNM 2 returned from maternity leave.

The PIC now submits a daily staffing update to the QM & CCO so that all unplanned leave can be addressed immediately and/or staffing risks escalated.

Call bell response times are now being monitored through updated software which has been added to the PICs laptop. Call bell response times are monitored weekly to ensure that they are within acceptable timeframes and if they are not then this is discussed with the team at the daily huddles. This remains an ongoing improvement initiative.

Recruitment campaigns were escalated for:

- Healthcare assistants.
- Housekeeping staff/MTAs.
- Activities.
- APIC.

The following positions have now been filled and commenced from recent recruitment:

1 x 1 WTE Staff Nurse.
2 x 2 WTE HCAs.
2 x 2 WTE MTAs and 1 x 0.75 WTE MTA.
1 x 0.25 WTE Activity coordinator.

The following positions have now been filled:

2 x 2 WTE SN has been recruited and we await a start date following garda vetting.
1 x 1 WTE SN has returned from parents leave.
1 x 1 WTE APIC awaiting garda vetting.

The use of agency staff continues and has been and is monitored to ensure continuity and consistency of care. We have worked consistently with the same agencies and they have supplied regular staff to us. A contingency staffing plan is in place across the group has been developed and can be activated for the rapid mobilisation of suitably qualified staff to cover all care and housekeeping roles in the event of unplanned absences thus maintaining continuity and safety of care.

The full complement of staff is in place in the laundry and housekeeping departments. There are two housekeepers and one laundry person on duty daily. A review of the laundry processes has also been undertaken to facilitate a smoother operation.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Daily allocations of staff were reviewed and revised and priority residents are allocated to specific staff. The nursing team now also have specific allocations for their shift. The care team report back to the nurses at the daily huddle. This is supervised by the clinical

management team. Sufficient staffing is rostered daily. Daily cleaning and deep cleaning schedules have been reviewed and revised and in addition to daily sign-offs the clinical management team are also conducting spot-checks. Housekeeping staff have received a refresher and/or induction into the appropriate cleaning methods. Additional training and supervision is ongoing. An independent company was contracted to review the nursing documentation and a subsequent action plan is in development – overseen by the CCO. One-to-one mentorship with the nursing staff in relation to nursing documentation has been provided. Daily reviews of the care plans and narrative/progress notes are undertaken by the Quality Manager and the PIC and immediate issues addressed. The CCO has also conducted spot checks and provided feedback where required. However, the development and improvement programme is still in progress. Clinical Nurse Managers complete daily walk-rounds using a structured checklist to monitor and supervise care delivery, housekeeping standards, and nursing documentation. Observations and findings are documented and reviewed as part of the weekly governance meetings. Weekly audits of nursing documentation are undertaken by CNM1 and CNM2. Audit outcomes are reviewed by the Person in Charge. Where gaps are identified, staff members are provided with targeted support, including one-to-one coaching and follow-up within five working days.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

A full audit of all staff files was conducted and all staff files are now up-to-date. Verifications for professional registrations is completed. Documentary evidence of current registration is retained in each staff member's file. Nursing documentation standards have been reviewed and guidance and daily mentorship provided to all nursing staff regarding: daily progress notes/narrative notes, care interventions and accurate recording of each residents condition. Digital signature processes have been reviewed and we can assure that there is full identification (first names and surnames) of all staff members. The staff roster is updated as changes arise and a daily staffing update is emailed to the QM and the CCO. Complaints are managed in line with the centre's policy and a detailed analysis of same has been undertaken.

Regulation 23: Governance and management	Not Compliant

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

The provider acknowledges the findings in relation to governance, resource allocation, management structure, and oversight systems. A comprehensive review has been undertaken to address gaps in clearly defined roles and responsibilities, deputising

arrangements, and the effectiveness of monitoring, audit, and escalation processes. The following actions have been implemented and are being progressed to ensure a safe, well-governed, and effectively managed service with clear accountability at all levels. The clinical management structure has now been restored and additional management hours approved for the weekly roster. The full complement of staff is in place for the housekeeping and laundry departments and all staff in these departments have received training appropriate to their role. Increased frequency of environmental and IPC audits. A comprehensive re-audit will be conducted by the Director of Care, Quality and Standards (date of completion 25/05/2026). A weekly governance meeting has commenced attended by the PIC, QM, CNM Provider and CCO. This meeting tracks all clinical and operational KPIs, enables a forum for the identification and/or escalation of risk and clearly outlines each persons role and responsibilities for the week ahead. The provider has allocated an additional resource by allocating the companies Director of Care, Quality and Standards to oversee day-to-day operations and to assist the centre to reach safe standards and regulatory compliance. The weekly governance meeting agenda includes: Staffing review, Departmental review, Safe care, Risk management, Complaints review, IPC and antimicrobial stewardship, Clinical oversight (review of KPIs and red flags) and Review of audits conducted. The revised escalation process ensures identified risks are escalated promptly to senior management and in addition to this the CCO reports further on a weekly basis to the Senior Leadership Team. The audit programme has been strengthened to include an increase of IPC and environmental audits, audits of all updated care plans and call bell response times audits. All audits generate a Quality Improvement Plan (QIP) where required, with clearly assigned responsibilities and timeframes. Resident feedback has been sought through surveys. Action plans include assigned responsibility, completion dates and monitoring of effectiveness. The provider and the CCO have instigated quality assurance reviews to monitor compliance. Staff meetings and enhanced huddles and supervision assist in supporting staff to have the required knowledge and skills relevant to their role – this is an ongoing process. Systems for communicating key clinical information have been strengthened. The structure of the daily handovers has been advanced. The Director of Care, Quality and Standards submits a monthly Quality and Safety Report to the Senior Leadership Team, incorporating audit findings, risk register updates, incidents, complaints, and staffing metrics to support ongoing oversight and continuous quality improvement.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Following the inspection a satisfaction survey was distributed to all residents and their NSPs. Additional residents meetings were also scheduled. Feedback on all aspects of the service was sought. Ideas and suggestions from the residents were taken on board and action plans implemented. As part of the quarterly triangulation all feedback was analysed for any trends or patterns and action was taken where required. It ensures that if any complaints are received that they are responded to in line with the regulatory requirements and the centres complaints procedure The Director of Care, Quality and

Standards and the PIC monitors the feedback weekly. Complaints handling training has been completed by the clinical management team. All resident feedback is reviewed at the weekly governance meetings.

Regulation 27: Infection control	Not Compliant

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

An additional 3.5 WTE staff have been employed for the housekeeping/MTA roles. These staff have been inducted to their roles. A full deep clean of the centre has taken place (06/03/2026-08/03/2026) by an external contractor. Enhanced cleaning schedules have been implemented throughout the centre. The full complement of housekeeping resources is now rostered in order to ensure effective cleaning coverage. Cleaning schedules are now monitored and signed off by the nurse manager on duty or nurse in charge. Deep cleaning of resident and communal areas has been completed and a revised deep cleaning schedule is in place. The frequency of infection prevention and control audits has been increased. Refresher infection prevention and control training, hand hygiene and donning and doffing training is underway for all staff. Equipment and cleaning materials have been reviewed to ensure availability and suitability and improvements are in progress. Environmental hygiene standards are reviewed weekly by all members of the senior management/leadership team when onsite and a senior management checklist is in place. An IPC lead from another centre in the group who has the relevant expertise has visited to provide guidance, direction and support. IPC link facilitator training is being sourced for additional members of the nursing team.

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:

Both the Director of Care, Quality and Standards and the CCO have clinically reviewed every resident and ensured that appropriate skin care is in place for each resident. Every residents MUST was re-reviewed by the QM and a report with an action plan submitted to the CCO. The PIC has re-assessed each residents Barthel dependency score. The Director of Care, Quality and Standards and the CCO are reviewing all updated assessments and care plans to ensure that they have recorded accurate information. Additional guidance and recommendations were sought from an external contractor with specialist knowledge in care planning. One-to-one mentorship is ongoing with each member of the nursing team. This mentorship has included education re. residents autonomy, right to self-determination and use of person-centred language in addition to the correct recording of their clinical needs and plan of care. Additional formal training

will supplement this one-to-one mentorship. Residents with cognitive impairment who at times may decline care will have alternative interventions and support strategies offered at other times and this is documented. Human rights education is being completed by all nursing staff. This is phase one of our improvement plan.

Regulation 6: Health care	Not Compliant

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

Residents requiring psychological or specialist supports are being referred promptly through the appropriate routes. Nursing documentation standards have been set and these standards are being monitored daily by the home management team and weekly by the senior management team. Residents healthcare needs are reviewed by the Director of Care, Quality and Standards and the CCO to ensure timely interventions. Evidence-based nursing care practices are being monitored through the enhanced supervised interventions which are in place. Clinical supervision and support for nursing staff has been strengthened through increased senior management oversight. Robust support from the local GP practice is in place.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: A full review of the social, therapeutic and recreational programme has taken place. An additional 0.25 WTE activities person has been employed thus enabling activities to be scheduled 7 days per week. The programme has been developed in consultation with the residents and based on their feedback. The PIC and the Director of Care, Quality and Standards monitor the schedule to ensure that it reflects the residents interests, capacities and preferences. A recreational space has been made more accessible in the "Clancy" area so that residents have more choice regarding where they would like to spend their time, improvements are being made to the "Butler" wing to facilitate a stronger nurse presence in the communal areas and further improvements are also underway for the enhancement of the "quiet room". These changes are underway and supported by the groups Head of Facilities. Work is ongoing to develop all staff in terms of their ability to engage in a meaningful way with residents. Staff allocations have been reviewed so that activities can take place in tandem with other daily routines. Care plans are being monitored to ensure that residents are consulted regarding all care interventions and decisions affecting them.

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	Red	18/06/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	05/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the	Not Compliant	Red	31/05/2026

	designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Red	18/06/2026
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Not Compliant	Red	20/04/2026
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	30/06/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the	Not Compliant	Orange	17/07/2026

	standards published by the Authority are in place and are implemented by staff.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	31/03/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	31/03/2026
Regulation 34(3)	The registered provider shall take such steps as are reasonable to give effect as soon as possible and to the greatest extent practicable to any improvements recommended by a	Not Compliant	Orange	31/03/2026

	complaints or review officer.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/03/2026
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	29/05/2026
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and	Not Compliant	Orange	29/05/2026

	may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.			
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	29/05/2026
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	29/05/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with	Not Compliant	Orange	30/06/2026

	the rights of other residents.			