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:	11 June 2026
Centre ID:	OSV-0007883
Fieldwork ID:	MON-0050752

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:	48

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 11 June 2026	08:45hrs to 17:15hrs	Leanne Crowe	Lead
Thursday 11 June 2026	08:45hrs to 17:15hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

This was an unannounced inspection, conducted over the course of one day. The inspectors spoke with many residents about their experience of living in Sonas Nursing Home Carrick-on-Suir. While most of the residents spoken with were complimentary about the staff and the care that they received, a small number of residents expressed dissatisfaction regarding the quality of the food, complaints management, the response times of staff to requests of assistance and the quality of care.

Sonas Nursing Home Carrick-on-Suir is a purpose-built, single-storey facility providing accommodation for 55 residents. There were 48 residents living in the centre on the day of the inspection. There was a variety of comfortable communal spaces, including day rooms and dining rooms, available to residents.

On arrival to the centre, inspectors were greeted by members of the management team. Inspectors completed a walk around the centre, giving an opportunity to review the living environment and to meet with residents and staff. Residents were generally complimentary of the care provided to them by staff, however, a small number of residents expressed concern that their care needs were not being appropriately met.

A suspected outbreak of infection was ongoing at the time of the inspection. Consequently, many residents who were symptomatic of infection were isolating in their bedrooms. Signage on bedroom doors clearly indicated which residents were currently isolating. There were appropriate supplies of personal protective equipment (PPE) and alcohol hand gel situated outside these bedrooms, and clinical hand wash sinks were located across various corridors of the centre. A dedicated team of staff was allocated to care for residents that were determined to be symptomatic of the infection. The general environment was visibly clean on the day of the inspection. Housekeeping staff were present and engaged in cleaning tasks throughout the day of the inspection, including enhanced cleaning protocols due to the suspected outbreak in the centre. These staff members were generally found to be knowledgeable in cleaning practices and processes.

Inspectors spoke with a number of staff throughout the inspection. A number of staff demonstrated a good knowledge of the residents they provided care to, and referred to residents and their individual needs in a respectful manner. However, inspectors noted that some staff used language that did not promote residents' dignity or rights.

The inspectors observed the residents' afternoon meal. Residents were found to be seated and waiting for an extended period before their meals were served to them. When inspectors raised this with staff supervising the dining room, the rationale given for this delay demonstrated a poor understanding of residents' rights and

choice. The food served to residents appeared to be well-presented and appetising. While many residents enjoyed their food, others expressed dissatisfaction with the quality of the meals served to them. One resident was observed to refuse their meal, and inspectors saw that they were not offered an alternative by staff.

Friends and families were facilitated to visit residents, and inspectors observed many visitors coming and going throughout the day of the inspection. Inspectors spoke with a number of visitors who were generally satisfied with the care provided to their loved ones.

Residents' bedrooms were clean, tidy and well-maintained. Bedrooms were personalised with residents' belongings such as photos, artwork and ornaments. Residents told the inspectors that they had sufficient storage for their clothes and personal possessions.

While some residents who spoke with inspectors expressed confidence that any complaints they may have would be addressed promptly by the management team, a small number of residents stated that they had previously raised complaints that had not been satisfactorily managed or responded to.

The programme of activities had been enhanced since the previous inspection. Additional staff were available to ensure that residents were provided with sufficient opportunities to engage with activities, in line with their own capacities and capabilities. A schedule of activities displayed in communal areas indicated that the planned activities for the day of the inspection included an exercise class, choir, reminiscence therapy, TV and the rosary. Residents were observed enjoying the exercise class and various other activities throughout the day. Residents who spoke with inspectors stated that they enjoyed the activities, but they would also like to go on outings. This had been raised in a recent residents' meeting, and an action plan was being developed to address this.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to review the action taken by the provider in response to significant findings of non-compliance relating to governance and management and staffing, as found on a previous inspection of the centre in March 2026.

On this inspection, inspectors reviewed the non-compliant regulations found on the last inspection and found that the registered provider had taken some action to

address the areas of risk and the areas requiring quality improvement. The provider had strengthened the systems of management and oversight in the centre, as well as the management and allocation of resources. The centre was observed to be clean, and the housekeeping staff was appropriately resourced.

However, while acknowledging the improvements in the management systems for monitoring the quality and safety of the service, inspectors found that some aspects of these systems were not fully effective, particularly in relation to the oversight of the assessment, monitoring and review of residents' health status, the promotion of residents' rights and the submission of notifications to the Chief Inspector. While the provider had committed to reviewing all resident assessment and care planning documentation, only seven residents had their care plans updated at the time of this inspection. Additionally, inspectors found that the overall arrangements in place to ensure that the privacy and dignity of each resident in the centre was upheld, were not clearly documented in the centre's statement of purpose. Inspectors observed that the dignity of residents was not always upheld within the documentation of residents' care, or in the way that some staff spoke about the needs of the residents.

The registered provider of Sonas Nursing Home Carrick-on-Suir is Sonas Asset Holdings Limited. A company director represented the registered provider entity in communications with the Chief Inspector. A member of the executive management team participated in the management of the centre. The management structure had changed since the previous inspection in March 2026. At the time of the inspection, the positions of quality manager and assistant director of nursing (ADON) were vacant, however, a director for clinical care, quality and standards was providing supervision and support to the nursing management team on an interim basis. A clinical nurse manager (CNM) was deputising for the person in charge on the day of the inspection. The remaining staff complement was comprised of a team of nursing staff, health care assistants, a physiotherapist, a social care practitioner, catering, housekeeping, activities staff and maintenance staff. Inspectors found that the resourcing of staff to the housekeeping department had improved since the last inspection.

Since the previous inspection, the provider had commenced the process of developing governance and management systems to ensure a safe and consistent service was being provided to residents. These were being implemented and overseen by members of the management team. The clinical management hours had been increased and a weekly governance meeting had been established. Daily walkabouts by the management teams took place, and records of these were available for review. Additionally, a member of the management team attended the centre at weekends. A programme of clinical and operational audits were being carried out on a scheduled basis. For example, a new form of call bell audit had been implemented since the previous inspection, which supported the management team to accurately assess the response times to call bells being activated. Key clinical indicators with regard to the quality of care provided to residents were collated on a weekly basis, including data on the incidence of falls, infections, wounds, medication errors and complaints. The data collected and findings from audits were discussed at regular governance meetings and used to identify any

deficits in the service. Action plans were consequently developed and assigned to named individuals for completion.

Following the last inspection the provider had commissioned an external review of the centre's care planning process and there was an action plan in place to address the identified issues. However, the implementation of these changes had not been completed in a timely manner, and the risks associated with inappropriate and incorrect care plans had not been fully mitigated by the management team.

A review of staffing resources had been completed since the previous inspection, and a number of staff had been recruited to various departments within the nursing home. On the day of the inspection, staffing levels in the centre were found to be sufficient for the number of residents and for the size and layout of the centre. The team providing direct care to residents consisted of registered nurses and a team of health care assistants.

A review of staff training records evidenced that staff had completed mandatory training to support the provision of safe care to residents, including fire safety, manual handling and safeguarding of residents. Some additional training had commenced in relation to falls management and wound management, in response to areas of quality improvement being identified by management. However, inspectors found that the provider had not yet commenced staff training in human rights, which had formed part of the provider's compliance plan response to the previous inspection in March 2026.

The inspector reviewed a sample of staff files. These contained all of the information and documentation required by Schedule 2 of the regulations, including evidence of An Garda Síochána vetting disclosures. All nurses working in the centre had active nursing registration with the Nursing and Midwifery Board of Ireland (NMBI).

An electronic record of all accidents and incidents involving residents that occurred in the centre was maintained. A review of records identified that not all incidents, as specified by the regulations, were notified to the Chief Inspector.

The management of complaints was not fully in line with the requirements of the regulations. The provider had a complaints policy and procedure which clearly outlined the process of raising a complaint or a concern. A complaints log was maintained, and the records contained in this log demonstrated that these complaints were appropriately investigated and responded to. However, inspectors found that some expressions of dissatisfaction that were known to staff had not been identified as a complaint and therefore had not been managed in line with the centre's own policy.

Regulation 15: Staffing

There was sufficient staff with an appropriate skill mix on duty to meet the needs of the current residents, having regard to current occupancy of the centre, for the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

All staff were up-to-date with mandatory training in moving and handling practices, fire safety and safeguarding of residents. However, staff had not been supported to complete human rights training, as committed to by the provider in the compliance plan response from the previous inspection.

While the supervision of staff had improved since the previous inspection, the arrangements in place were not fully effective to ensure that care was delivered in line with residents' assessed needs and individual choices.

Judgment: Substantially compliant

Regulation 21: Records

While management of records with respect to staff files and the staff rosters was now in line with regulatory requirements, daily records for residents continued to be insufficiently detailed to reflect resident's current health and condition.

Judgment: Substantially compliant

Regulation 23: Governance and management

Notwithstanding the actions taken by the provider to improve the oversight of the centre, governance and management of the centre was not yet fully aligned with the requirements of registration. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- poor oversight of nursing documentation. While all residents' care plans were in the process of being revised, inspectors found that some of the residents' care plans reviewed did not accurately reflect the assessment of residents' needs,
- inadequate oversight of complaints management,

- inadequate arrangements in place to ensure appropriate supervision and oversight of staff,
- poor oversight of incidents involving residents to ensure statutory notifications were submitted to the Chief Inspector within the required time frame.

Judgment: Not compliant

Regulation 31: Notification of incidents

Two notifiable incidents had not been submitted to the Chief Inspector within the required time-frame.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaint records found that not all complaints were recorded, managed and responded to, in line with the regulatory requirements. Inspectors found that issues of dissatisfaction, communicated by both residents and residents' families had been documented as concerns and not managed within the complaints management system. As a result, issues remained unresolved and there was no evidence of appropriate communication and follow up with the complainants.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that some action had been taken to address the findings of the last inspection in March 2026 with respect to reviewing care documentation and the overall cleanliness of the centre. This inspection found that care was delivered to residents to a satisfactory standard. Residents told inspectors that their quality of life was good and that they enjoyed the programme of activities on offer. The safety of all residents had improved due to the action taken by the provider to address the cleanliness of the centre. The action taken in relation to the oversight and management, by the provider, of the health and safety of all residents, as described in the capacity and capability section of this report, was beginning to make a positive impact on the service. However, inspectors found that the dignity of

residents was not always upheld in the centre, and that this staff culture was continuing to have a negative impact on the overall care and well-being of residents.

A review of a sample of resident care documentation found that while a small number of care plans had been reviewed and updated since the last inspection, the majority of the care plans reviewed were not person-centres and did not contain the information required to guide good quality care. In addition, the language used within a number of care plans was not in line with professional documentation guidelines and did not ensure that the dignity of the resident was upheld.

The centre was experiencing a suspected outbreak of inspection on the day of the inspection. The action by the management team and staff was in line with the requirements of national guidance, standards and regulations. The centre also had enhanced cleaning resources in place. The overall cleanliness of the centre had improved since the last inspection, and the provider had put resources in place to ensure that these improvements could be sustained.

The provider had reviewed the risk management systems in the centre. An escalating trend of residents' falls had been identified and an action plan was in place to address this risk. An electronic risk register was in place and used to manage some known clinical and environmental risks within the centre.

Visiting was observed to be unrestricted in the centre. Visitors were observed coming and going to the centre throughout the day of the inspection. Feedback from visitors was generally positive.

Improvements were noted in the provision of activities to residents. An activity schedule was in place and there were staff available to facilitate these activities. Group physiotherapy sessions were in progress on the afternoon of the inspection. Resident meetings were scheduled and documented, giving residents an opportunity to raise issues and suggestions in relation to the organisation of the centre. Notwithstanding these improvements, care planning documents reviewed demonstrated a poor understanding of residents' rights and the importance of self-determination for older people. Residents were not always afforded choice in how they spent their social time.

Regulation 11: Visits

Visiting was facilitated in the centre, in line with the requirements of the regulations.

Judgment: Compliant

Regulation 27: Infection control

The arrangements in place for the management of infection prevention and control had improved since the last inspection. The centre was in the process of managing an outbreak of infection. The procedures were observed to be in line with national guidelines. The centre was cleaned to an appropriate standard.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

All residents had an assessment of care needs and an associated care plan on file. The quality of care plans was inconsistent. The small number of care plans that had been updated since the last inspection were person-centred and detailed. This demonstrated the effectiveness of recent guidance and training in this area. However, the majority of care plans reviewed had not been updated and did not contain the information required to guide a high standard of care, as identified on the previous inspection.

Judgment: Not compliant

Regulation 6: Health care

A review of the daily progress notes for residents found that some records continued to be duplicated and therefore did not accurately reflect changes to the needs of the residents. This is not in line with the requirements of professional guidance.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights were not fully upheld in the centre. Staff spoken with, and care documents reviewed, evidenced a poor understanding of residents' rights, autonomy, and positive risk-taking. Residents were not always supported to make choices about 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sonas Nursing Home Carrick-on-Suir OSV-0007883

Inspection ID: MON-0050752

Date of inspection: 11/06/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant

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

The Provider acknowledges the findings in relation to staff training and supervision and has implemented the following actions:

• All staff have been assigned the Residents' Human Rights Approach training programme, with training compliance monitored through the centre's training matrix. Currently, 80% of staff have completed the programme, with the remaining staff scheduled to complete training by 31 July 2026.

• In addition, in-house Human Rights training has been arranged, with training sessions scheduled throughout August and September 2026 to further strengthen staff knowledge, understanding and application of a rights-based approach to care.

• The Person in Charge is facilitating education sessions on the FREDA Principles to support staff in embedding a human rights-based approach to care and promoting residents' rights, dignity, choice, independence and autonomy. Following completion of this programme, weekly QUIS observations will be undertaken by the PIC, ADON or CNM to monitor staff-resident interactions and identify opportunities for further learning and improvement. Findings will be reviewed through supervision and governance processes, with targeted support and education provided where required.

• Daily management walk-rounds have been enhanced and include direct observation of staff practice, resident experiences, the promotion of residents' rights and adherence to person-centred care principles. Records of walk-round findings are maintained, with immediate feedback, coaching and reflective discussions provided where required. Findings and learning are communicated through daily safety pauses, handovers and a communication book, which staff are required to read and sign to confirm awareness of key messages and actions.

The effectiveness of training and supervision arrangements will be monitored through daily walk-rounds, weekly QUIS audits, resident feedback, complaints analysis, care practice observations and governance meetings to ensure care is consistently delivered in line with residents' assessed needs, preferences and rights

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Provider acknowledges the findings in relation to the quality and accuracy of residents' records.
An enhanced audit process replaces the previous spot-check system. Weekly audits are completed using a documentation audit tool which will assess the accuracy, completeness and person-centred nature of residents' records, ensuring that documentation reflects residents' current health status, assessed needs, interventions provided and outcomes achieved.
Audit findings are reviewed with individual staff members and action plans are implemented where improvements are required.
Monthly analysis of audit outcomes is undertaken to identify trends and support continuous improvement in documentation practices

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 and oversight of care planning, complaints management, staff supervision and statutory notifications.
Governance arrangements have been further strengthened through:
• Appointment of an Assistant Director of Nursing (ADON) to support governance, care planning oversight and clinical supervision.
• Implementation of a Clinical Governance Planner to ensure all audits, reviews, meetings and compliance activities are scheduled, monitored and completed.
• Replacement of weekly spot checks with formal weekly audits using audit tools to strengthen oversight of care plans, narrative notes and documentation standards.
• Audit findings are reviewed individually with staff members, corrective actions are implemented and monthly trend analysis is undertaken to identify recurring themes and opportunities for improvement.
• Daily management walk-rounds are documented and include clear action plans. Outcomes are communicated through safety pauses, handovers and the communication book.
• Weekly governance meetings review complaints, incidents, care planning, residents' rights, audit findings and quality indicators.
• Weekly KPIs are reviewed and monitored by the Senior Leadership Team to ensure effective organisational oversight and support timely interventions where required.
The Statement of Purpose has been reviewed and updated to clearly reflect the arrangements in place to safeguard residents' privacy, dignity, autonomy and rights.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The Provider acknowledges the findings relating to statutory notifications.
Since the inspection:
• A review of incident reporting and notification systems has been completed.
• A Clinical Governance Planner has been implemented to ensure regulatory obligations are monitored and achieved.
• The PIC maintains oversight through weekly review of the incident register and statutory notification tracker.
• Incidents, notifications and associated KPIs are reviewed weekly by the Senior Leadership Team to ensure all notifications are submitted within required regulatory timeframes and that trends and learning opportunities are identified.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Provider acknowledges the findings in relation to complaints management and the recording of expressions of dissatisfaction.
The Person in Charge is committed to fostering an open and positive culture where residents, families and staff feel confident in raising complaints, concerns and feedback, recognising these as valuable opportunities for learning and service improvement.

All staff have been assigned the Complaints Management Training Programme to ensure complaints, concerns and expressions of dissatisfaction are recognised, recorded and managed in line with the centre's policy and regulatory requirements.
The Person in Charge, as the nominated Complaints Officer, ensures all complaints are acknowledged, investigated, documented and responded to within the required timeframes. The ADON reviews the complaints register regularly to maintain oversight, identify trends and support quality improvement.

Following the inspection, the concern raised regarding food quality was immediately addressed, recorded on the electronic care record system and discussed with the resident. Ongoing follow-up is undertaken to ensure the resident remains satisfied with the actions taken.
Complaints, incidents, resident feedback, audit findings and quality indicators are reviewed through the centre's quarterly triangulation process. Where trends are identified, timely action plans are implemented and monitored through the governance framework. The Senior Leadership Team also reviews complaints and incidents regularly to ensure regulatory compliance and support continuous service improvement.

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:
The Provider acknowledges the findings in relation to assessment and care planning. Residents' assessments and care plans are continuing to be comprehensively reviewed to ensure they are person-centred, accurately reflect residents' assessed needs, preferences and choices, and provide clear guidance to staff in the delivery of care. The review of care plans remains on the centre's live governance register and progress is monitored through weekly governance meetings.
The ADON has dedicated responsibility for care plan oversight and is providing one-to-one support, coaching and education to nursing staff to improve assessment and care planning practices. This extensive review process is supporting both improvements in documentation quality and staff knowledge.
A structured action plan is in place, with all care plans scheduled to be reviewed and updated by 15 August 2026. Weekly audits using the an audit tool are completed by the management team, with findings reviewed through governance meetings and addressed through supervision, education and quality improvement actions.

Progress is monitored through weekly governance meetings to ensure improvements in care planning are sustained and that residents' needs, preferences, choices and rights are appropriately reflected in their care documentation

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Provider acknowledges the findings in relation to the quality and accuracy of residents' daily nursing records, specifically the duplication of narrative notes which did not always reflect residents' current health status.
The Person in Charge has provided education to nursing staff to reinforce the importance of maintaining accurate, contemporaneous, person-centred and professional records. In addition, further in-house documentation and record-keeping training has been arranged for September 2026.
Weekly spot-checks of narrative notes and care plans have been replaced with structured weekly audits using the an audit tool to strengthen oversight of documentation quality, accuracy and person-centredness. Audit findings are reviewed with individual staff members and any identified deficits are addressed through guidance, supervision and ongoing education.
The ADON provides ongoing support, education and oversight to nursing staff to ensure documentation complies with professional standards and accurately reflects residents' healthcare needs and care provided. Audit outcomes and learning are reviewed through governance meetings to support continuous quality improvement and the delivery of a high standard of evidence-based nursing care.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Provider acknowledges the findings in relation to residents' rights and is committed to promoting a culture that respects and supports residents' dignity, autonomy, choice, independence and meaningful participation in all aspects of daily life.

• Staff have been supported to complete Residents' Human Rights Approach programme .Further in-house Human Rights training has been arranged throughout August and September 2026 to strengthen staff knowledge and application of a rights-based approach to care.

• Daily management walk-rounds and the implementation of weekly QUIS observations is providing ongoing monitoring of residents' rights, dignity, choice and autonomy.

• Fortnightly resident Forums have been introduced to strengthen resident participation and engagement.

• Residents are encouraged to undertake meaningful roles within the centre, including involvement in staff interview panels to provide feedback from a resident perspective, supporting activities, assisting with internal mail distribution and leading the rosary.

• Following feedback received through resident meetings, an outing has been organised for 15th August 2026, with future outings planned in partnership with residents.

• Residents' assessments and care plans are being reviewed to ensure their preferences, wishes, goals and choices are clearly documented and respected.

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	30/09/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2026
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.	Substantially Compliant	Yellow	31/08/2026
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	Not Compliant	Orange	31/08/2026

	effectively monitored.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	31/07/2026
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	31/08/2026
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	Not Compliant	Orange	31/08/2026

	resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall 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.	Not Compliant	Orange	31/08/2026
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.	Substantially Compliant	Yellow	30/09/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with	Not Compliant	Orange	31/08/2026

	the rights of other residents.			