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:	Croft Nursing Home
Name of provider:	Croft Nursing Home Limited
Address of centre:	2 Goldenbridge Walk, Inchicore, Dublin 8
Type of inspection:	Unannounced
Date of inspection:	21 July 2026
Centre ID:	OSV-0000028
Fieldwork ID:	MON-0050819

About the designated centre

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

The Croft Nursing Home is located just a few miles from Dublin city centre and within walking distance of Inchicore village. The home is a single-storey building providing accommodation for 36 long stay beds. Accommodation is configured to address the needs of all potential residents and includes superior single, companion and shared accommodation with assisted bath and shower rooms. There are a number of lounges and reading areas located throughout the building. The centre also has access to a secure garden area for residents to use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

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
Tuesday 21 July 2026	08:10hrs to 16:10hrs	Aoife Byrne	Lead

What residents told us and what inspectors observed

This was an unannounced inspection, carried out over one day, by an inspector of social services. The inspector met with many of the residents who were living in the centre and based on the observations and discussions it was evident that The Croft Nursing Home was a nice place to live. Staff were seen to be familiar with the residents' needs and preferences, and were observed to be respectful in their interactions with residents.

The Croft Nursing Home is located in Inchicore, Dublin 8. The centre is registered to provide care for a maximum of 36 residents and had no vacancies on the day of the inspection.

On arrival to the centre the inspector was met by the assistant director of nursing (ADON) who was covering for the person in charge who was on leave. The inspector observed that the centre was short staffed on the morning of the inspection with the ADON and one agency staff nurse onsite until cover was provided at 10am from another centre within the group. On review of the roster, the inspector noted that the ADON was scheduled to cover nursing duties in addition to cover for the person in charge, on a number of occasions in addition to the day of the inspection.

The inspector spent time walking through the centre, which provided an opportunity to meet residents and staff. There was a warm and friendly atmosphere, with residents practicing exercises in the hallway, while others were observed to be up and sitting in the day room waiting for breakfast.

The inspector observed that there were new clinical hand wash sinks fitted in the centre, and corridors and bedroom doors had been painted since the last inspection in March '26. There was an ongoing programme of refurbishment works to improve the premises that was seen to be in progress on the day of the inspection. The courtyard was nicely maintained with plenty of flowers surrounding the courtyard. The maintanence shed had a new colourful mural painted on it, and the inspector was informed by staff and residents that this was a project the residents were involved in during the summer which they thoroughly enjoyed.

There was a dedicated activity staff member on duty who provided a varied programme of activities. The inspector observed different activities that had been arranged for residents to enjoy such as bean bag toss, a quiz and music. It was observed at the end of the day that a resident played guitar and started a music session for the residents. There was a lot of good fun and humour amongst staff and residents throughout the day. In conversation with some of the residents, they spoke about attending the local mens shed and an outing to knock that was arranged in May 2026. A small number of men set up a performance group and

were called "The boys from the Croft", they had completed one performance so far and were looking forward to arranging more gigs.

The daily menu was displayed in the dining room which outlined the meals for lunch time and the evening meal. The inspector observed the dining experience and saw that some residents were eating in the dining room while others were in the day room. The inspector saw eight residents being served their meals in the day room. Those residents who could eat independently had their meals placed on overbed tables or coffee tables and were sitting in armchairs which did not provide good postural positioning for eating.The inspector was informed by staff that some of the residents wishes to remain in the day room for their meals. During the lunch time service, residents were given a choice of two options, roast beef or chicken. There were adequate levels of staff to support residents, and those who required assistance with their meals, received support from staff in a respectful and dignified manner. Meals were well-presented, and there was a choice of drinks also available. Residents who spoke to the inspectors were complimentary regarding the food provided, reporting that the temperature of the food was appropriate and they had sufficient portions.

The inspector observed that staff and residents interactions were found to be person centred, kind and respectful. The inspector spoke with residents who were very complimentary in their feedback and expressed satisfaction with the care, staff, food and activities. Overall, residents said that staff were kind and attentive to their needs and that "they cant do enough for us".

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended) and to inform a registration renewal. This inspection also followed up on the compliance plan from the inspection in August 2025 in relation to fire precautions and March 2026 in relation to infection prevention and control. Additionally, solicited and unsolicited information was reviewed.

The inspector found that while the majority of actions set out in the providers compliance plans had been progressed, action taken by the provider to address the findings from the IPC inspection in March 2026 resulted in a breach of condition 1 of the centres registration. The inspector saw that a resident shower room had been converted into a medication room without prior notification to the Office of the Chief

Inspector, a warning meeting was subsequently held with the provider in relation to the breach of regulations.

Croft Nursing Home Limited is the registered provider of Croft Nursing Home , which is part of the wider Silver Stream Health Care Group who operates a number of other designated centres nationally. The person in charge was supported by an ADON, clinical nurse manager (CNM), registered nurses, care assistants, an activities coordinator, housekeeping, catering, laundry, administrative and maintenance staff. Additional support was provided by management from the wider Silverstream group such as clinical governance and facilities managers.

The inspector saw that there were systems in place to deliver quality care to residents, and this was continuously monitored with oversight from senior management team. The systems included a comprehensive auditing programme, which was overseen by the person in charge. Both clinical and non-clinical audits were completed on a monthly and quarterly basis, and quality improvement action plans were in place to address any issues identified. Audits included care plans, falls prevention and management, restrictive practice and infection prevention and control.

The routine allocation of the ADON to carry out staff nurse duties, rather than working in a supernumery capacity resulted in deficits in the day-to-day management and oversight of the service. Additionally, this staffing arrangement did not align with the staffing resource's outlined within the statement of purpose. This is further discussed under Regulation 15: Staffing.

Records maintained in the centre were in paper and electronic format. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available for each member of staff. There was a record of current registration details for all staff nurses with the with the Nursing and Midwifery Board of Ireland. However, the inspector saw that residents' records were not stored securely. On the day of the inspection the inspector observed clinical handover sheets and care plans were easily accessible at reception.

Notifiable incidents which included an incident of alleged abuse had not been notified to the Chief Inspector in line with the requirements of the regulations. This is further discussed under Regulation 31: Notification of Incidents.

There was a complaints policy which contained the requirements of the regulations.The inspector reviewed a sample of both verbal and written complaints and saw that they had all been dealt with appropriately. Residents were aware of the policy in place for managing complaints and told inspectors that they felt safe and supported to raise any concerns with the staff team.

Regulation 15: Staffing

The number and skill mix of staff in the centre was not appropriate having regard to the size and layout of the building. This was evidenced by the inspectors findings on the day of the inspection, where the only member of the management team, the ADON was scheduled to work as a staff nurse in addition to covering for the person in charge which is required to be a supernumery position. The inspector found that the redeployment of the ADON to staff nurse duties was part of routine rostering practices and not a measure taken in response to unplanned staff absences. As a result staff were not consistently working within their designated roles as set out in the Statement of purpose against which the centre is registered.

This is a repeat finding from two previous inspections in 2025.

Judgment: Not compliant

Regulation 21: Records

Not all records were stored securely, and therefore residents' personal information was easily accessible to unauthorised persons. For example:

- Clinical handover sheets were seen left unattended on the counter at reception and on a medication trolley.
- Residents care plans were easily accessible and left unattended at reception.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems to ensure that the service provided was consistent and effectively monitored were not sufficiently robust. This was evidenced by the following:

- The oversight systems in place to ensure that staffing levels and skill mix was appropriate to the size and layout of the centre were ineffective. The redeployment of ADON blurred the lines of authority and accountability, resulting in uncertainty among staff regarding the management structure and their respective roles and responsibilities.
- Actions committed to in the previous inspection compliance plan were not actioned for example; the oversight of fire safety specifically in relation to fire evacuation drills which will be discussed further under Regulation 28: Fire precautions
- Management systems in place to ensure that the required notifications were submitted to the Chief Inspector within the specified timeframes outlined in

the regulations, were insufficient, as further detailed under Regulation 31: Notification of incidents.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not submitted all notifiable incidents within two working days of their occurrence as set out under Schedule 4 of the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were seen to be handled in line with the centre's complaints policy. A copy of the complaints procedure was displayed in prominent positions throughout the centre, and included details of the complaints officer and what to do in the event complainants were not happy with the outcome of the complaint.

Judgment: Compliant

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider is in breach of condition 1 of registration and failed to notify the Chief Inspector of changes to the footprint of the centre, and to the change in use of rooms. For example:

- A shower room had been reconfigured to create a medication room.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the residents living in The Croft Nursing Home were being well cared for by a team of committed staff who supported them to enjoy a good quality of life. Feedback received from residents and visitors was all

positive, particularly in respect of the staff who worked in the centre and the activities available.

The registered provider had completed all actions to address findings in relation to infection prevention and control and the premises committed to in their compliance plan from the previous inspection,. A total of three new clinical hand wash basins had been installed in the centre to improve and promote good hand hygiene practices amongst staff. Alcohol hand gel dispensers were installed at the point of care. In addition, the inspector observed that the dedicated housekeeping room was reconfigured to include a janitorial sink , mop bucket station and secure chemical storage. The centre was overall clean and free from clutter on the day of inspection. There was a large amount of refurbishment completed and a programme of works scheduled to ensure compliance under Regulation 17: Premises by the 31 August 2026 which was committed to in the compliance plan from the inspection in March 2026.

The inspector followed up on a number of safeguarding notifications submitted to the Chief Inspector since the last inspection. From this review, the inspector found that where an allegation of abuse was made, the person in charge completed an investigation into the allegation and identified outcomes and learnings. Learnings and recommendations from the investigations were shared with the staff team, residents and family members as appropriate, and residents' care plans were updated as required to improve outcomes and care experiences for residents.

The registered provider was acting as a pension agent for 13 residents in the centre. There was a separate pension account established for residents which their pensions were paid, and appropriate policies and procedures were in place to ensure the safeguarding of residents finances in the centre.

A review of fire precautions in the centre found that the provider had completed the majority of actions set out in the compliance plan submitted following the previous inspection. Fire stopping materials in compartment walls were installed. A new fire door was installed in the reception area to ensure suitable compartmentation was in place. In addition, there was a new fire safety risk assessment (FSRA) completed in July 2026 and while some fire doors were observed to not fully close while on inspection, these were identified in the FSRA and was within the timeframe for actioning. Notwithstanding the actions taken, the fire drills of the largest compartment were not occurring regularly and this is discussed further under Regulation 28: Fire precautions.

Regulation 27: Infection control

A review of infection prevention and control in the centre found that the provider had completed the actions set out in the compliance plan submitted following the previous inspection.

Judgment: Compliant

Regulation 28: Fire precautions

While regular fire drills were being completed at the centre, they did not include the dependency level of the residents in the compartment. There was one fire drill for the largest compartment since the last inspection however, it only included the evacuation of four out of the 13 residents living in the compartment. This meant that the provider could not be assured that all residents in the higher risk large compartment areas could be evacuated in a reasonable time in the event of a fire, including at times of low staff numbers such as night time.

This is a repeat finding.

Judgment: Substantially compliant

Regulation 8: Protection

There was an up- to-date safeguarding policy available. Incidents and allegations of abuse had been appropriately investigated by the person in charge.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Quality and safety	
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Croft Nursing Home OSV-0000028

Inspection ID: MON-0050819

Date of inspection: 21/07/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The registered provider has reviewed the staffing and management arrangements following the findings of the inspection.

The previous compliance plan incorrectly stated that the revised Statement of Purpose had been in place since 26 May 2025. This was a typographical error. The revised Statement of Purpose was dated May 2026.

The revised Statement of Purpose dated May 2026 and submitted as part of the re-registration process, provides for the ADON role 0.5 WTE supernumerary management time. Rostering arrangements will ensure that this protected management allocation is maintained and that the ADON is not routinely deployed to direct nursing duties in a manner that compromises the management and clinical oversight function.
Two new Clinical Nurse Managers have been recruited to strengthen clinical leadership and oversight within the centre. The management structure will support senior nursing staff to maintain a visible clinical presence while also providing clear oversight of standards, care delivery and staff practice.

The revised management structure is supported by weekly clinical governance oversight to review key clinical and quality matters, including incidents, complaints, safeguarding, audits, care planning, clinical indicators, risks and identified areas requiring improvement. Weekly HR meetings have also been introduced to provide additional oversight of recruitment, vacancies and staffing requirements.

The Registered Provider in conjunction with PIC are satisfied that the proposed structure of a supernumerary PIC, 0.5 WTE ADON and two CNMs within the nursing staff complement provides an appropriate management and clinical leadership structure for the centre.
The effectiveness of these arrangements will continue to be monitored and reviewed to ensure that management and clinical governance resources remain appropriate and responsive to the needs of residents.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Immediate corrective action has been taken following the inspection findings regarding the storage of confidential resident information. Nursing staff had been leaving documents at the administration desk for subsequent filing or shredding. A designated confidential filing box and shredder have now been provided in the treatment room so that staff can securely file or dispose of documentation immediately. Staff have been reminded that clinical handover sheets, care plans and other resident information must not be left unattended in areas accessible to residents, visitors or other unauthorised persons. The administration desk is also being reorganised to provide appropriate secure storage so that resident files and confidential documentation can be locked away when not in use. The PIC and management team will complete routine checks of reception, clinical and administration areas to ensure confidential records are stored securely. Any non-compliance identified will be addressed immediately with the relevant staff member.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The management structure is displayed throughout the centre, and induction for new employees includes an introduction to key members of the management team and clarification of reporting arrangements. Two new CNMs have been recruited to strengthen clinical oversight and support the PIC and ADON. Monthly management meetings will resume and will provide structured oversight of staffing, clinical governance, audits, incidents, quality improvement actions and regulatory compliance.	

Biweekly HR meetings have also been introduced to strengthen oversight of staffing, recruitment and workforce planning.
The audit schedule identifies the respective responsibilities of the PIC/DON, ADON and CNMs, providing clearer accountability for completion and follow-up of audits and actions.

A review confirmed that one required notification had not been submitted within the prescribed timeframe, relating to an incident involving missing money.
Corrective action was taken immediately once this omission was identified, and the notification was subsequently submitted to HIQA on 29 July 2026.
Learnings from the incident has been shared with the centre's management team.
Serious incidents are reviewed through weekly clinical governance meetings, with additional review by the Clinical Governance Team where appropriate, to ensure that potential statutory notifications are identified and submitted within the required timeframe.

A report is also completed for the RPR Team identifying all open Quality Improvement Plans, including actions arising from regulatory inspections and compliance plans. This provides additional oversight of progress, outstanding actions and agreed completion dates, and supports timely escalation where actions are not progressing within the required timeframe.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Clinical Governance Team and Person in Charge have reviewed the notification process following identification that one required notification, relating to missing money, had not been submitted within the required timeframe.
Corrective action was taken immediately and the notification was submitted to HIQA on 29 July 2026.
The learnings arising from this omission has been shared with the centre's management team and across the wider group.
All incidents are reviewed by the Clinical Governance Team to provide an additional level of oversight and further discussed at the weekly meetings to identify any notification requirements.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant

Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration:
Applications by registered providers for the variation or removal of conditions of registration:

The registered provider acknowledges that the conversion of a communal shower room into a medication room resulted in a change to the use and configuration of the registered premises without the required regulatory process being completed.
Following engagement with the Office of the Chief Inspector, the provider has reviewed both the specific works undertaken and the wider governance process for changes to the registered premises.
The unauthorised change will be addressed in accordance with the requirements arising from the regulatory engagement with the Chief Inspector. The room will be returned to its previously registered configuration. A work plan has been submitted to the Chief Inspector for approval. Once approved, the required works will be completed within 4 weeks.

A formal internal approval process will apply to any future proposed works which may affect the registered footprint, use of rooms or facilities available to residents.

The Estates Engineer/Facilities team and centre management will not commence works affecting the registered premises until the regulatory implications have been reviewed and approval to proceed has been confirmed.
The Registered Provider Representative will maintain oversight of this process.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The fire drill programme has been reviewed following the inspection finding that the drill completed in the largest compartment did not test the evacuation of all residents accommodated within that compartment.
The largest compartment will be a specific focus of the centre's fire drill programme each month for the remainder of 2026.

A minimum of one fire drill will continue to be completed each month. The centre will also aim to complete an additional drill every second month to test evacuation arrangements within other compartments.
The PIC will review the outcome of each drill and ensure that any required corrective action is completed.
The monthly programme will provide ongoing assurance that the evacuation arrangements for the largest compartment can be implemented safely and effectively, including during periods of minimum staffing.

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
Registration Regulation 7 (1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition or conditions of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	30/10/2026
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2026

Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	16/09/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	16/09/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/09/2026

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	16/09/2026