



**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:	Ennis Road Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Ennis Road, Meelick, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	23 July 2025
Centre ID:	OSV-0005768
Fieldwork ID:	MON-0047759

About the designated centre

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

Ennis Road Care Facility is a designated centre located on the outskirts of Limerick city on the old Ennis Road. It is registered to accommodate a maximum of 84 residents. It is a purpose-built single storey facility, where bedroom accommodation comprises 54 single and 15 twin rooms, all with en-suite facilities of shower, toilet and hand-wash basin. Additional toilet facilities are available throughout the centre. Communal areas comprise a spacious dining room, a large garden room (day room), activities room, smoking room, and oratory. Main reception is an expansive space with a grand piano, fire place, and lots of seating hubs; off the main reception is the hairdressers' salon and an area to be developed into a coffee dock. There are additional comfortable seating areas off the activities room. Residents have access to two enclosed gardens with walkways, seating and raised flower beds. Ennis Road Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	79
--	----

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
Wednesday 23 July 2025	19:15hrs to 22:15hrs	Leanne Crowe	Lead
Thursday 24 July 2025	09:00hrs to 17:15hrs	Leanne Crowe	Lead
Wednesday 23 July 2025	19:15hrs to 22:15hrs	Catherine Sweeney	Support
Wednesday 23 July 2025	19:15hrs to 22:15hrs	Una Fitzgerald	Support
Thursday 24 July 2025	09:00hrs to 17:15hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

This was a two day inspection. Over the course of the two days, inspectors interacted with a large number of residents and visitors. Overall, residents and visitors provided mixed feedback about their experience of Ennis Road Care Facility. Some residents stated that staff as individuals were doing their best, describing the care provided to them as "smashing" or "ten out of ten". However, the majority of residents spoken with were dissatisfied with the totality of the service provided.

Residents expressed concern at the high level of staff turnover that had occurred recently. Consequently, they felt that staff did not always know their assessed needs, their interests or personal preferences. Residents were unhappy with the staffing levels and many said that staff were often too busy to attend to their needs in a timely manner, and described examples of their personal routines being impacted by the availability of staff. For example, they said that the length of time they had to wait for assistance and support from staff was too long. In addition, a number of residents told inspectors that they felt staff often ignored their requests, or that care was delivered according to a schedule, as opposed to a person-centered approach that factored in the residents' choices. In addition, residents expressed dissatisfaction with the quality of the food provided and the registered provider's ability to respond to feedback.

A small number of residents told inspectors that they did not always feel safe residing in the centre, for example, when staff delivering care to them did not engage with them or explain what they were doing. In addition, some residents who observed their peers waiting extended periods of time to receive assistance said that this made them apprehensive about their own mobility deteriorating and subsequently becoming reliant on staff to support them.

Ennis Road Care Facility is situated on the Ennis Road, Meelick, County Clare. The centre is a purpose-built, ground floor facility providing accommodation for 84 residents. This unannounced, risk inspection took place over one evening and one day. There were 79 residents accommodated in the centre on the days of the inspection.

Inspectors arrived at the centre for an unannounced evening inspection at 7.15pm. Inspectors had to wait to gain entry to the centre as the main desk was initially unattended. Upon entering the reception area, inspectors were informed that while there were three staff nurses on duty, there was nobody on site with the delegated authority to be in charge of the centre. Following a brief introductory meeting with the nursing staff that were present, inspectors conducted a walk through the building, reviewing the living environment, and engaging with residents, visitors and staff. A number of residents were having evening tea or watching television in the large communal sitting/dining room, while multiple residents were retiring to bed or were being assisted by staff with their personal care needs. The person representing

the provider entity, an operations manager and a clinical nurse manager attended the centre after 9.30pm to facilitate the inspection.

While staff were allocated to supervise communal areas on the first evening of the inspection, and provided assistance upon request, inspectors observed that staff did not use this opportunity to converse or engage with residents. Some visitors who spoke with inspectors described times where residents in communal rooms were not supervised by staff, particularly early in the morning. Inspectors noted that on the second day of the inspection, staff allocated to these areas were observed to be more engaged with residents while also completing any tasks, such as providing drinks and other forms of assistance.

On the first evening of the inspection, inspectors noted that staff were not always available to provide timely assistance to residents that required it. A substantial number of residents told inspectors that they often had to wait extended periods of time for assistance from staff. Multiple residents said that they often experienced long delays in their call-bell being answered, with some adding that staff would attend their room to turn off the call-bell, prior to informing residents that they would be back to them shortly. When asked if they knew why this occurred, the residents stated they were of the understanding that the staff were too busy with other residents. Inspectors observed a number of occasions where this occurred across both days of the inspection. Relatives told inspectors that they often walked the corridors looking for staff to provide assistance to their loved ones, and incidents of this were also observed by inspectors during the first evening of the inspection. Two residents told inspectors that when they ask for assistance, staff sometimes "ignore" them or "pretend like I don't exist".

Friends and families were facilitated to visit residents, and inspectors observed many visitors coming and going throughout the evening and daytime. 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. This included concerns about staffing levels, 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. Visitors also talked about poor management of residents' laundry, describing occasions where clothes were not hung up properly by staff, were damaged or misplaced. Lastly, visitors did not always feel that concerns they raised were listened to or meaningfully responded to by staff. They gave examples of not receiving a response after submitting a complaint, being told that their complaint could not be taken at a given time due to the absence of a senior staff member, or having to follow up with the provider to receive an update on how their complaint was being managed.

Inspectors spoke with a number of staff throughout both days of inspection. Staff confirmed that each night, a schedule of non-direct care duties were allocated to staff, such as laundry and cleaning, which impacted on their availability to answer call-bells, deliver care in a timely manner, or respect residents' choices and routines, such as those who wished to stay up later than the times these scheduled tasks were due to commence. An example of this occurring was observed by inspectors during the inspection. One resident told inspectors that they could not go to their

bed at a time of their choice each day, and inspectors observed staff attempting to transfer the resident to their bedroom while the resident stated that they did not wish to go. The resident then returned to the sitting room, with assistance of staff. These communications with residents, and the observations of the inspectors on the days of the inspection, reflected practices that did not promote a rights-based approach to care.

On the first evening of the inspection, many residents were observed spending the evening in communal areas or in their bedrooms, meeting with visitors or watching television. On the second day of the inspection, a programme of activities was carried out, which was enjoyed by many of the residents. This included walks in the enclosed garden area, painting and live music. A large number of residents and visitors gathered in the reception area to enjoy the live music, and some were observed dancing with staff. A number of residents also performed songs with the musician. During this time, staff provided drinks and snacks to all in attendance.

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;

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended)
- review unsolicited information received by the Chief Inspector pertaining to concerns about the governance and management of the centre, food and nutrition, the management of residents with responsive behaviours, staffing levels and the supervision of staff, environmental hygiene, the management of complaints and the quality of care provided to residents. This information was found to be partially substantiated on this inspection
- follow up on solicited information submitted to the Chief Inspector by the registered provider in relation to the safeguarding of residents.

Previous to this inspection, an unannounced risk inspection had taken place in May 2025. Significant risk and regulatory non-compliance had been identified on that inspection, where the provider had not taken all necessary action to identify and implement effective risk management systems to ensure the safety and welfare of residents. The provider had submitted a compliance plan outlining the actions that they would take to address the concerns identified, which was in the process of being implemented at the time of this inspection.

The inspection was carried out over one evening and the following day. The inspectors found that the registered provider had failed to ensure that there were

sufficient resources in place to effectively deliver care to residents. Additionally, the systems of management and oversight in place to communicate key information to staff, to monitor the management of complaints and the quality and safety of care to residents were not adequate, and at times reflected an institutional culture of care delivery. These deficits were found to significantly impact on residents' safety, residents' choice, and the quality of care delivered to residents. Consequently, an urgent compliance plan request was issued to the provider following the inspection, seeking time-bound assurances in relation to:

- The systems of management and oversight to ensure that the service provided was safe, consistent and effectively monitored
- The management of resources to ensure the effective delivery of care to all residents, while also ensuring that tasks related to environmental hygiene and the management of laundry could be completed appropriately
- The oversight and management of complaints
- The systems in place to ensure that residents could exercise choice in their daily routines.

A response to the urgent compliance plan was submitted by the registered provider to the Chief Inspector, which was accepted.

The registered provider of Ennis Road Care Facility is Beech Lodge Care Facility Limited. A director of the company represented the registered provider entity. An operations manager attended the centre each week to oversee non-clinical areas of the service. The person in charge worked in the centre on a full-time basis and was supported in their role by an assistant director of nursing (ADON), who deputised in their absence, as well as two clinical nurse managers, nursing staff, health care assistants, a physiotherapist, catering, housekeeping, activities staff and maintenance staff.

Overall, this inspection found that the quality of residents' lives in the centre was significantly impacted by inadequate staffing levels and the provider's failure to listen and respond to the concerns and requests of residents. While some improvement was noted in relation to the documentation of residents' care records since the inspection in May 2025, this inspection found that residents received a service that did not meet the required standards of care or the requirements of the regulations.

Inspectors found that the organisation and management of staffing resources was not effective, and that this adversely impacted the quality of care delivered to residents. Inspectors found that the level of housekeeping and kitchen staff was not adequate to meet the needs of residents in the centre, and that these duties were supplemented by care assistant staff during night time hours. The centre's staffing levels had recently been impacted by an increase in staff turnover. In response to this, the provider had temporarily utilised agency staff and recruited a number of additional staff, some of whom had already commenced employment in the centre. However, inspectors found that on the days of the inspection, the number and skill mix of staff was not always sufficient for the size and layout of the centre. Rosters indicated that from 9.45pm on the first night of the inspection, four care assistants

and three nurses were on duty to attend to the needs of 78 residents. While there were adequate levels of care staff on duty, they were reallocated from care provision to catering and housekeeping duties. For example, staff spoke with and records reviewed by inspectors demonstrated that care assistants were assigned a schedule of various duties to complete during the night, including laundry, kitchen and housekeeping tasks, commencing at 10.30pm.

Inspectors found that the requirement to complete these tasks impacted the staff's availability to provide quality care to residents, particularly in relation to their personal care and social care needs. For example, inspectors observed a resident being brought to bed by staff, despite the resident clearly vocalising a wish to remain in the sitting room. Inspectors also observed delays in staff responding to residents' request for assistance, either in person or through the ringing of call-bells. Feedback from staff, visitors and residents supported the finding that residents were not always provided with assistance in a timely manner.

The systems of communication in place to share key information with staff regarding residents' assessed care needs were not effective. For example, inspectors observed two handover meetings on the evening of the inspection, which were not attended by care assistants, where contemporaneous information regarding residents' care needs were communicated. While handover sheets outlining residents' care needs were provided to all care assistants, not all care assistants who spoke with inspectors were able to demonstrate awareness of information outlined in the handover sheets. Additionally, safeguarding plans were in place to ensure the safety of a number of residents, but only some staff spoken with were able to confirm what identified risk had informed the development of these care plans.

The systems in place to ensure that all staff had appropriate training and knowledge to deliver effective and safe care were not adequate. The provider had failed to assess the effectiveness of the training delivered to staff. A number of staff spoken with were unable to demonstrate an appropriate level of knowledge in relation to the training that they had completed, such as the procedures to follow in response to the fire alarm alerting.

The arrangements in place to supervise staff were not adequate to protect and promote the care and welfare of residents. Inspectors found that staff were poorly allocated and that the systems to supervise the direct provision of care were not sufficient to ensure that residents' assessed care needs were met appropriately and in a timely manner. Consequently, inspectors observed delays in responding to call-bells and providing care to residents. Additionally, there were instances whereby residents' routines and choices were not respected by staff.

The management of complaints was not in line with the requirements of the regulations and, as a result, the quality of a number of areas of the service remained poor. While the centre had a complaints policy and procedure which outlined the process of raising a complaint or a concern, inspectors found that complaints from residents or visitors were not always recorded or managed in line with the centre's policy. Inspectors found that expressions of dissatisfaction submitted verbally or in writing to the registered provider had not been identified as

a complaint and therefore not managed in line with the centre's own policy. Additionally, residents and visitors told inspectors that action plans developed in response to complaints were not implemented in a timely manner, such as call-bell response times.

Regulation 15: Staffing

The provider had failed to ensure that there was a sufficient number or skill mix of staff to meet the assessed needs of residents, in accordance with the size and layout of the centre. This was evidenced by;

- On both days of the inspection, the staffing levels did not ensure that staff could always attend to residents' assessed needs or requests for assistance in a timely manner. This impacted negatively on residents' choice regarding their personal routines and preferences, as evidenced by residents' feedback and inspectors' observations during the days of the inspection
- Care staff on night duty were allocated the duties of catering, cleaning and laundry services for a period of up to five hours, which diminished their availability to attend to residents promptly and effectively.

The registered provider was issued with an urgent compliance plan following the days of the inspection in relation to staff supervision, to ensure residents' immediate wellbeing.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff training was not adequate to ensure the care and welfare of all residents. The registered provider had failed to assess the effective of training provided to staff, to ensure that staff had the required information to provide person-centred and effective care to residents. This was evidenced by;

- Incomplete staff training records. For example; there were 20 staff that had not attended their annual fire training. Multiple staff demonstrated poor awareness on what action to take in the event of the sounding of the fire alarm.
- There were five staff that did not have up-to-date training on safeguarding and safety. Multiple staff spoken with did not display knowledge of the current residents that had safeguarding care plans in place and the rationale for why extra monitoring of their care needs were in place.
- There were 25 staff who did not have training in the management of responsive behaviours. At the time of inspection, there were multiple

residents living in the centre with a diagnosis of advanced dementia that were assessed as at risk of presenting with responsive behaviours.

The registered provider had inadequate arrangements in place to ensure appropriate levels of staff supervision were in place. This lack of staff supervision, monitoring and support had a direct negative impact on the delivery of health and social care to residents. This was evidenced by;

- multiple residents reported waiting long periods of time for their call-bells to be answered. In addition, residents would have to wait a further period of time for assistance after their call-bell was responded to by staff.
- care staff were not appropriately supervised to ensure that care was delivered in line with residents' requests and choice. For example; residents were returned to bed at a time that was determined by the duties of the healthcare staff as opposed to the residents' preference.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider failed to ensure that the centre was adequately resourced, as the numbers and allocation of staff did not ensure that all residents' care needs were being met.

The inspection found that the management systems in place to ensure that the service provided was safe and consistently monitored was not effective, particularly in relation to the system in place to supervise, monitor and support staff. This was evidenced by;

- Inadequate oversight of direct provision of care, in line with residents' assessed needs
- Inadequate oversight of the management of complaints
- The failure to recognise and respond to practices that did not promote a rights-based approach to care.

The registered provider was issued with an urgent compliance plan following the days of the inspection, to ensure residents' immediate wellbeing.

Judgment: Not compliant

Regulation 34: Complaints procedure

The management of complaints was not aligned to the requirements of the regulations. For example;

- Complaints communicated to management by visitors and residents had not been documented or investigated by the complaints officer
- The registered provider had not ensured that staff had adequate knowledge of the centre's complaints procedures, including how to identify a complaint.

The registered provider was issued with an urgent compliance plan following the days of the inspection, to ensure residents' immediate wellbeing.

Judgment: Not compliant

Quality and safety

This inspection found that residents' rights were not fully upheld. As previously outlined, residents' expressed preferences were not always listened to or respected. Inspectors found that the quality and safety of care delivered to residents was compromised as a result of ineffective systems of governance and management, as described in the capacity and capability section of the report.

Residents' care plans and daily nursing notes were recorded through an electronic record system. Oversight of residents' clinical documentation had improved since the previous inspection. A review of nursing documentation indicated that residents' care plans were developed within 48 hours following admission to the centre to guide the care to be provided to residents. There was evidence that these were updated when a resident's condition changed.

The inspectors saw that a copy of transfer letters were kept in the resident's file in the electronic system. This letter included information such as the resident's weight, infections and vaccination status, and food and fluid consistency status. The nursing staff also ensured that upon residents' return to the designated centre, all relevant information was obtained from the discharge service and saved in residents' files.

Residents were reviewed by a medical practitioner, as required or requested. Referral systems were in place to ensure residents had timely access to health and social care professionals for additional professional expertise.

While there was an up-to-date safeguarding policy and procedure in place and the majority of staff had received safeguarding training, inspectors found that the registered provider had failed to take all reasonable measures to protect residents from abuse. At the time of the inspection, there were a number of residents with safeguarding care plans, which were in place to guide staff in implementing specific measures in order to ensure the residents' safety. However, multiple care staff

spoken with were either not aware of the identified risk that had prompted the development of these care plans, or referenced unrelated risks.

The provider did not act as a pension agent for any residents living in the centre.

While residents were consulted about and participated in the organisation of the service, their feedback was not always responded to appropriately. For example, a number of residents' meetings had been held this year. Residents had provided feedback about aspects of the service, such as call-bell response times in January 2025. While a plan was being progressed to address this issue, it had not yet been completed at the time of the inspection, seven months later. Additionally, inspectors identified a number of issues which had been raised by residents in these meetings, but were not being managed by the provider in line with the complaints' process.

There was a schedule of activities in place. Residents were observed to enjoy and participate in activities on the second day of the inspection, such as live music, painting and watching television. Outings also took place on a regular basis.

Regulation 25: Temporary absence or discharge of residents

Since the last inspection, the provider had reviewed the systems in place regarding the transfer or discharge of residents. It was now ensured that all relevant information about a resident was provided to the receiving hospital when transferring residents out of the centre.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents' care plans were developed following assessments of need using validated assessment tools. Care plans were observed to be person-centred, and updated at regular intervals. A review of a new resident's records showed that a care plan had been developed within 48 hours of admission.

Judgment: Compliant

Regulation 6: Health care

Care was not delivered in a person-centred manner, and was not provided in line with a high standard of evidenced-based nursing care, in accordance with professional guidance.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had failed to ensure that all reasonable measures to protect residents from abuse was in place in the designated centre. This was evidenced by the gaps in the staff knowledge of the current residents that required additional support and supervision as a result of identified safeguarding risks.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had not ensured that residents were supported to exercise choice, in line with their preferences. Multiple residents told inspectors that they had to wait extended periods of time to be brought between their bedrooms to the communal areas.

Multiple residents told inspectors that they felt their concerns raised at resident meetings were not listened to. For example, the minutes of residents' meetings evidenced that resident had voiced dissatisfaction with the answering of call-bells in January 2025. While some improvements had been seen, on the day of inspection this concern was ongoing, as voiced by residents to the inspectors.

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 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ennis Road Care Facility OSV-0005768

Inspection ID: MON-0047759

Date of inspection: 24/07/2025

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: Extended laundry and housekeeping hours implemented post inspection now ensure that all laundry and housekeeping activities are now managed within the day roster on a weekly basis. This change supports our commitment to providing consistent, timely, and high-quality care to residents in accordance with their assessed care needs. All staff have now been registered on the electronic communication system. This system ensures that all messages regarding residents' care needs are promptly communicated to relevant staff members. Management has full oversight and can monitor whether messages have been received, read and acknowledged. Where messages are not read or acknowledged, management will be able to follow up directly with the staff involved to address the issue. This improvement ensures that essential interventions and supports are consistently communicated and implemented, supporting the delivery of person-centered care. Several key actions have been taken to strengthen leadership, oversight, and staff development within the centre. The centre has now been divided into three defined sections: Bedroom 1–28, Bedroom 29–55, and Bedroom 56–84. Each section will have a designated Clinical Nurse Manager (CNM) or Senior Nurse as the team lead. These team leaders will be responsible for the provision of ongoing support and ensuring oversight over all residents in their care and staff under their supervision. The Nursing Home Management Team continue to meet individually with all staff members as part of scheduled mandatory meetings. During these sessions, a Training Needs Analysis will be carried out with each staff member. The findings from these meetings will be analysed, and additional support will be introduced as necessary to ensure that all staff are equipped to deliver high-quality, resident-centred care. Going forward, any significant changes in practice or policy will be discussed in advance with both residents and staff, ensuring a collaborative approach where all input is considered prior to implementation. As part of our commitment to ongoing development, point-of-care competencies have been assessed for all healthcare assistants. These audits will continue at least quarterly with each staff member or sooner if indicated. The results will be discussed individually to provide targeted feedback and support. Individual strengths and areas for development will be assessed to ensure that each staff	

member receives tailored supervision and guidance. These measures are being implemented to ensure that all duties are carried out with the appropriate levels of support, oversight, and supervision, thereby improving the overall quality of care delivered to residents.

Night management audit commences from 29/07/25 and continues at least every month. These measures aim to ensure all staff, including CNMs and Senior Nurses, have the support and resources they need to lead effectively and deliver high-quality, person-centered care to residents.

Robust monitoring systems have now been implemented to ensure appropriate oversight of staff training effectiveness and complaints management.

The management team will actively monitor the effectiveness of all staff training through direct observation of practice and structured question-and-answer sessions focused on key areas such as fire safety, safeguarding, complaints handling, residents' rights, and person-centred care. These evaluations will be documented and reviewed regularly to ensure ongoing staff competence and understanding.

In addition, feedback will be sought from residents on an ongoing basis to assess their experience of care, providing valuable feedback on the impact of staff training from the resident perspective. This will help ensure that training is not only completed but is being applied effectively in day-to-day care delivery. All findings from training evaluations and resident feedback will inform continuous quality improvement plans.

Complaints management systems have also been strengthened to ensure that any issues raised are addressed promptly and transparently, with learning outcomes clearly identified and implemented where applicable. These measures will ensure consistent oversight of staff development and contribute to a culture of accountability, responsiveness, and high-quality care.

Regulation 16: Training and staff development	Not Compliant
---	---------------

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

Post inspection the training matrix has been reviewed. The following training has taken place or is planned for the centre:

- Fire Training took place on site on the 19.08.2025 and 20.08.2025
- All staff have received a safeguarding refresher between 4th- 11th August 2025 in 4 separate meetings.
- Responsive Behaviours is planned for 30.09.2025 and 03.10.2025
- Manual Handling Training completed 29.08.2025
- Complaints management training took place on site 23.09.2025 and again on

25.09.2025. An additional session is arranged for 22.10.2025

A new system has been put in place to identify training needs within the Nursing Home. The matrix is reviewed weekly for deficits in training by the PiC and reported at the weekly Clinical Governance Meetings to plan training dates.

A New HR computerised platform is currently being implemented within the Nursing Home. Once implementation is completed the system will highlight the training needs for the home and a specific training plan including 'mop up' training can be devised.

To further support prompt response to resident needs, the call bell system already in place has been upgraded. The call bells record times are reviewed by the Person in Charge at least every other day to allow for monitoring of response times, and its effectiveness will be evaluated through resident's forum meetings.

Regulation 23: Governance and management

Not Compliant

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

The practice of allocating additional housekeeping and catering duties to health care assistant staff during the night has now ceased. We have ensured that these duties are completed during the day, in alignment with the extended laundry and housekeeping service hours. This change supports our commitment to providing consistent, timely, and high-quality care to residents in accordance with their assessed care needs.

All staff have now been registered on the electronic communication system. This system ensures that all messages regarding residents' care needs are promptly communicated to relevant staff members. Management has full oversight and can monitor whether messages have been received, read and acknowledged. Where messages are not read or acknowledged, management will be able to follow up directly with the staff involved to address the issue. This improvement ensures that essential interventions and supports are consistently communicated and implemented, supporting the delivery of person-centered care.

In response to the issue of duties being allocated to health care assistant staff without appropriate support and supervision, several key actions have been taken to strengthen leadership, oversight, and staff development within the centre.

The centre has now been divided into three defined sections: Bedroom 1–28, Bedroom 29–55, and Bedroom 56–84. Each section will have a designated Clinical Nurse Manager (CNM) or Senior Nurse as the team lead. These team leads will be responsible for ensuring appropriate skill mix, the provision of ongoing support, and the identification and facilitation of training needs for all staff under their supervision.

The Nursing Home Management Team continues to meet individually with all staff

members as part of scheduled mandatory meetings. The findings from these meetings will be analysed, and additional supports will be introduced as necessary to ensure that all staff are equipped to deliver high-quality, resident-centred care.

Going forward, any significant changes in practice or policy will be discussed in advance with both residents and staff, ensuring a collaborative approach where all input is considered prior to implementation.

As part of our commitment to ongoing development, point-of-care competencies will be assessed for all healthcare assistants within the next month. The results will be discussed individually to provide targeted feedback and support.

These measures are being implemented to ensure that all duties are carried out with the appropriate levels of support, oversight, and supervision, thereby improving the overall quality of care delivered to residents.

Night management audit is commenced from 29/07/25.

These measures aim to ensure all staff, including CNMs and Senior Nurses, have the support and resources they need to lead effectively and deliver high-quality, person-centered care to residents.

To address the identified gaps in oversight of staff training effectiveness and complaints management, robust monitoring systems have now been implemented.

The management team will actively monitor the effectiveness of all staff training through direct observation of practice and structured question-and-answer sessions focused on key areas such as fire safety, safeguarding, complaints handling, residents' rights, and person-centred care. These evaluations will be documented and reviewed regularly to ensure ongoing staff competence and understanding.

In addition, feedback will be sought from residents on an ongoing basis to assess their experience of care, providing valuable feedback on the impact of staff training from the resident perspective. This will help ensure that training is not only completed but is being applied effectively in day-to-day care delivery.

All findings from training evaluations and resident feedback will inform continuous quality improvement plans. Complaints management systems have also been strengthened to ensure that any issues raised are addressed promptly and transparently, with learning outcomes clearly identified and implemented where applicable.

These measures will ensure consistent oversight of staff development and contribute to a culture of accountability, responsiveness, and high-quality care.

Regulation 34: Complaints procedure

Not Compliant

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

We are committed to ensuring that all residents, their families, and representatives have access to an accessible, transparent, and effective complaints procedure. We recognise that actively listening to and addressing concerns is essential to maintaining high standards of care and continuously improving our services.

- A clearly defined and accessible complaints procedure is in place. It is prominently displayed throughout the centre, including in the reception area, all corridors, and in the residents' handbook.
- All complaints—regardless of size or nature—will be fully documented. This includes the nature of the complaint, the outcomes of any investigations, actions taken, any reviews requested, and the outcomes of those reviews. Findings will be shared with staff through the centre's communication system and at handover.
- Where quality improvement plans are developed in response to complaints, they will be actively monitored and discussed with relevant teams on a weekly basis. Documentation will clearly reflect the actions taken and outcomes achieved.
- A complaints log is maintained and reviewed weekly by the management team to identify trends, guide service improvements, and ensure timely resolution.
- Staff have received training in how to recognise and take a complaint, the importance of responding promptly and respectfully, and the correct process for escalating concerns. Staff have also be trained to provide feedback to residents, including estimated timeframes for resolution and details of the actions taken. Training has taken place on site on 23/09/2025 and 25/09/2025 with an additional session due to be held on 2/10/2025.
- All expressions of dissatisfaction—whether communicated verbally, in writing, or raised during residents' meetings—will now be formally recorded as complaints or concerns, in line with our complaints policy. To support this, residents' meetings will be attended by the Person in Charge (PIC) and/or the Assistant Director of Nursing (ADON). For residents who are unable to attend these meetings, their feedback will be captured through daily interactions with staff.
- The PIC is currently completing a comprehensive resident survey with all residents. The findings will be analysed and discussed with the management team, and appropriate Quality Improvement Plans (QIPs) have been developed and implemented.

Regulation 6: Health care

Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Post Inspection the PiC has met with each resident to discuss their choices, preferences and wishes around specific routines. All Care plans have been updated to reflect these choices. Staff are encouraged/reminded daily at handover to continue to reconfirm and establish residents' preferred choices at every engagement.

A satisfaction survey has been sent to all residents and families to enable those wishing to raise concerns to do so anonymously if necessary.

The Residents Right forum has met with residents and families several times post this inspection to discuss and inform them of their rights and the avenues available to them to escalate any issues of concern both internally and externally.

An external advocacy group has been contacted to meet with residents and hold an independent meeting to address any issues residents/families may have.

Regulation 8: Protection

Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
We recognise the importance of promoting resident autonomy and dignity, and we are committed to ensuring that all residents are supported in exercising their rights. A comprehensive survey has been conducted by the Person in Charge (PIC) with all residents that wished to partake to determine their individual preferences regarding waking and bedtime routines. These preferences are reflected in their care plan and staff roster, with enhancements made to ensure appropriate support is available during peak times of need.

To further strengthen supervision and enable greater responsiveness, a nurse was trialled until 12 midnight. Feedback from residents and staff indicated that these hours had a much more positive impact on care when redirected to the morning. Additional HCA supports in the evening ensured that residents who wish to stay up later are appropriately supported and that personal care needs are met in a timely and respectful manner. A shift lead/manager is on site until 19.45hrs, thereafter there is an appointed Nurse shift lead overnight.

A Residents' Rights Committee has also been established, the first meeting was held on Tuesday the 5th of August at 2pm with representation from residents, their nominated representatives, nurses, carers, housekeepers, catering and activities staff, administrative personnel, and management. This committee initially met twice monthly and provides an ongoing forum for feedback and improvements. The two resident specific meetings (Residents Feedback and Residents Rights) now occur monthly enabling residents to give feedback twice monthly.

Additionally, a Residents' Rights Poster is prominently displayed in the reception area and throughout all corridors to reinforce the commitment to upholding the rights and preferences of residents.

The practice of allocating additional housekeeping and catering duties to health care assistant staff during the night has now ceased. We have ensured that these duties are completed during the day, in alignment with the extended laundry and housekeeping service hours.

In order to ensure staff are knowledgeable and informed we have implemented the following for exchange of information:

Handover sheet updated to include safeguarding issues and ongoing events.

Safety Pause implemented at 11.30hrs, where all heads of departments meet and exchange information relating to residents and the designated centre.

Staff have received safeguard refresher on site with senior management and open safeguarding issues are now discussed daily at handover.

An external advocacy group has been contacted to connect with residents and complete an independent meeting to establish if any further issues arise around choice and preferences.

Regulation 9: Residents' rights

Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: A Residents Rights committee has been formed with two meetings having taken place on site. These meetings have been chaired by the Director of Nursing. It is hoped that this responsibility will be removed from the DoN and we are currently seeking nominations for a Chairperson for this committee and residents will cast their vote on their preferred candidate in the coming weeks. This will ensure residents have an opportunity to voice concerns in private and they be brought forward to the management by an independent individual.

The PiC has met with each resident within the Nursing Home. Staff on the floor have received mentoring and support in respect of choice. Additionally, all staff attended meetings on site to discuss choice and resident preferences and wishes. Any concerns voiced during these meetings were documented and actioned immediately.

Care plans have been updated to include residents' wishes around bedtimes and specific routines.

Staff are updated daily at handover and safety pause meetings. Staff are also encouraged to confirm repeatedly throughout a task the resident wishes as due to cognitive decline this may change.

The management team continue to complete 'point of care' monitoring. All Care assistants have been assessed, and audits will continue for another 3/12

Post inspection an additional shift of 15.00hrs to 21.00hrs was added to the rota to support residents.

The call bell system is being upgraded to ensure appropriate records and logs are maintained for auditing. In the interim the management in the centre is conducting weekly call bell audits.

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	06/10/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	03/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	26/08/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient	Not Compliant	Red	28/08/2025

	resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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	15/09/2025
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Not Compliant	Red	30/07/2025
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	Substantially Compliant	Yellow	30/07/2025

	receipt of the complaint.			
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	Red	02/10/2025
Regulation 34(7)(b)	The registered provider shall ensure that all staff are aware of the designated centre's complaints procedures, including how to identify a complaint.	Not Compliant	Red	02/10/2025
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	Substantially Compliant	Yellow	05/08/2025

	guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	11/08/2025
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 the rights of other residents.	Not Compliant	Red	05/08/2025