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:	Brabazon House
Name of provider:	The Brabazon Trust
Address of centre:	2 Gilford Road, Sandymount, Dublin 4
Type of inspection:	Unannounced
Date of inspection:	04 February 2026
Centre ID:	OSV-0000017
Fieldwork ID:	MON-0049061

About the designated centre

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

Brabazon House Nursing Home is a 51-bed centre providing residential and convalescent care services to males and females over the age of 18 years. The service is nurse-led by the person in charge and delivers 24-hour care to residents with a range of low to maximum dependency needs. Admissions are primarily accepted from people living in the sheltered accommodation apartments in Brabazon Court and Strand Road, although direct admissions to the centre are accepted, in exceptional circumstances, subject to bed availability. The building is an original Edwardian House (circa 1902) that has been extended and refurbished while retaining some of its older features. It is located in a quiet road just off the Strand Road close to the strand and Dublin Bay. Local amenities include nearby shopping centres, restaurants, libraries and parks and also the strand. Accommodation for residents is across two floors. The centre contains 39 single bedrooms of which 33 have en-suite facilities. There are also three twin and two three bedded rooms. Communal facilities include assisted shower bathroom and toilets, dining room, two sitting rooms, an activity room, sensory room and a library. There are small rest areas situated on the ground floor at reception and on the first floor outside the hairdressing room which residents and visitors can enjoy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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 4 February 2026	08:10hrs to 16:55hrs	Catherine Furey	Lead
Wednesday 4 February 2026	08:10hrs to 16:55hrs	Bernadette McDonald	Support
Wednesday 4 February 2026	08:10hrs to 16:55hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out by three inspectors over one day. The purpose of the inspection was to monitor ongoing compliance with the regulations and standards, with a specific focus on infection prevention and control (IPC). Inspectors engaged in conversation with many residents, and in more detail with eight residents. Overall, the feedback on life in the Brabazon House was very good. One resident said they had 'waited years to come here' and that they were very happy. Another resident said that the staff were absolutely excellent at their jobs. One resident said the food was beautiful and there was plenty of it.

Inspectors arrived to the centre in the morning and were welcomed in by the person in charge. Following a brief opening meeting, inspectors observed the care and social environment, met with residents, visitors and staff, and reviewed a selection of documentation to gain an insight into the lived experience of residents living in Brabazon House.

The centre is located in a scenic area close to Sandymount village and strand in Dublin 4 and is registered for 51 residents. There were 49 residents living in the centre on the day of the inspection. The premises is originally an Edwardian house that has been extended and refurbished over time. Some parts of the centre retain some of the period features of that era, such as high ceilings and original brickwork, which contributes to the classical feel and décor of the centre. There were some minor areas of wear and tear evident throughout and there was a progressive maintenance plan in place to ensure all upgrades were completed.

The inspectors found the centre very clean and the provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning checklists and colour-coded cloths and mops to reduce the chance of cross infection. Similarly, housekeeping staff spoken with had a good understanding of the cleaning needs of the centre. However, more oversight of the disinfection requirements was required, including correct dilution. More detail was also required for the deep cleaning schedule, outlining exactly what constitutes a deep clean and when it should take place. This and other findings are further outlined under Regulation 23: Governance and management and 27: Infection control.

Personal clothing, linen and bedding was laundered on-site. Residents spoken with had no complaints about the laundry processes. The infrastructure of the laundry storage room supported the functional separation of the clean and dirty laundry processes. However, inappropriate storage of staff items, unlabelled residents' clothing, and a pressure cushion were seen in this room creating a cross-contamination risk.

The inspectors observed the dining experience at lunchtime. The main dining room was spacious and bright with large windows out to the garden. Many residents gathered at dining tables and were chatting and enjoying their meal. There were different menu choices every day and the food was nicely plated and appeared appetising and wholesome. Some residents chose to take their meals in their rooms and inspectors saw that the food was delivered hot by staff directly from the kitchen. Staff sat beside residents and discreetly offered assistance and encouragement when required. There was plenty of hot and cold drinks on offer during mealtimes and throughout the day.

Residents were observed walking independently, and with assistance through the communal areas and corridors of the centre. The corridors upstairs were narrower than the ground floor, however there were assistive handrails on each level. Some residents' rooms were accessed by steps and there were chair lifts in place should the resident require them. Residents could use the lifts and stairs to go between the floors.

While signage instructed the return of toiletries to bedrooms, several communal bathrooms contained unlabeled toiletries and continence wear. The presence of these shared, non-identifiable items can lead to cross-contamination and fails to protect the individual dignity of residents.

Although hand-wash sinks were present and accessible within the facility, the number and distribution were insufficient to meet clinical demand. Staff told inspectors they were using resident sinks to wash their hands. This practice poses a cross-infection risk for both staff and residents. The sluice room (room dedicated for the reprocessing of bedpans, urinals and commodes) was clean, contained a bedpan washer/disinfector, hand hygiene sink and commode pan rack and drip trays for the storage of bedpans and urinals post disinfection. Temporary failure of the bedpan washer was corrected via a maintenance reset during the inspection.

The organisation of storage space required review as items were seen stored incorrectly. Resident wash bowls were seen stacked in each other, dirty linen baskets were stored next to a clean linen trolley and crash mats were seen placed on beds. All of these practices pose a risk of cross-infection between residents.

There was a good activities schedule in place and each resident had the weekly activities plan in their bedroom. This was displayed in the communal areas also. During the day, groups of residents engaged in an exercise class and creating ''Life Story'' books with the activities coordinator. A dementia-specific therapy was also carried out in one of the smaller sitting rooms. Residents said they enjoyed the activities on offer, and this was reflected in the minutes of residents' meetings, and recent surveys, which showed high levels of satisfaction with the activities and outings on offer.

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.

Capacity and capability

Overall, the centre was operating a service which generally produced good outcomes for residents. Nonetheless, inspectors identified some gaps in the clinical governance systems in the centre, which could pose a risk to the care and welfare of residents. Deficits were also identified in other areas including assessment and care planning, staff training and infection control which did not provide full assurance that the service provided was consistent and effectively monitored.

On the day of the inspection the centre's system of clinical assessment had failed to identify significant deterioration of a wound. Preventative measures had not been taken to reduce the risk posed to the resident. Due to these concerns an immediate action was issued to the provider under Regulation 5: Individual assessment and care plan. The provider was requested to take immediate action by referring the resident to the appropriate external specialist services, and implement preventative measures including the provision of appropriate pressure-relieving equipment. This was completed by the end of the inspection.

The registered provider of Brabazon House is The Brabazon Trust. This is a charitable organisation with a board of nine committee members who oversee the operational management of the centre. Two committee members were present in the centre during the inspection, one of whom is the secretary of the Brabazon Trust, and to whom the person in charge reports directly to. A general Manager also works full-time in the centre, and was on planned leave on the day of inspection. The person in charge was supported in the role by two clinical nurse managers who were supernumerary and who generally worked opposite each other. There were deputising arrangements in place for any planned or unplanned absences of the person in charge. Teams of staff nurses, healthcare assistants, activities co-ordinators and maintenance staff provided further clinical and social support to the residents. The registered provider had outsourced housekeeping and the catering to external providers. The centre had a nominated Infection Prevention and Control (IPC) link practitioner to increase awareness of IPC and antimicrobial stewardship.

Staffing levels were appropriate to meet the individually and collectively assessed needs of the residents. Staffing levels were stable, with minimal use of external agency staff. There was a schedule of in-person and online training for all staff. As described under Regulation 16: Training and staff development, inspectors identified areas of practice where staff had knowledge gaps. Additionally, many important training modules such as safeguarding of vulnerable people and fire training were overdue for completion. Inspectors were informed that training had been booked for the coming months.

A schedule of audits was in place which were undertaken by nursing management and covered a range of topics. Audits were scored, and tracked to monitor progress. However, they did not detect some of the poor findings observed on the day of

inspection. Quality improvement plans (QIP) were developed in line with audit findings, but were not always actioned with a responsible person. There were management systems occurring such as clinical governance meetings, staff meetings and residents meetings. IPC was on the agenda of these meetings. Minutes of these meetings were reviewed and a discussion held that sling hoists should not be stored together and should be labelled. However, all sling hoists observed by inspectors did not have any identifier on them. This failure to assign slings to specific residents poses a significant IPC risk, as shared usage can facilitate the transmission of skin-borne infections. Other agenda items included safeguarding, training, activities and food and nutrition for residents.

The provider had implemented a number of *Legionella* bacteria controls in the centre's water supply. For example, infrequently used outlets and showers were run weekly. Additionally, documentation was available to confirm that the hot and cold water supply was routinely tested for *Legionella* to monitor the effectiveness of controls.

Regulation 15: Staffing

The registered provider ensured that the number and skill-mix of staff was appropriate, having regard to the assessed needs of the residents and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the record of staff training identified that not all staff were up-to-date with important training modules to support them in their respective roles:

- All staff nurses were overdue for training in basic life support which was due to be renewed every two years as per local policy.
  Twenty-seven of the 57 staff members were overdue for annual training in fire safety. Some staff members had last completed this training in 2022.
  Sixteen of the 57 staff members were overdue for training in the safeguarding of vulnerable residents. Inspectors noted that maintenance, administrative and laundry staff had no record of completing this training.

Based on the overall findings of the inspection, additional knowledge deficits in the areas of wound care and auditing were identified. Staff and management had no record of additional training in these areas.

In addition, staff supervision required strengthening as recurrent examples of poor practices were observed, including inappropriate storage and IPC practices did not consistently demonstrate the implementation of training principles into practice

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place did not provide full assurance that the service provided is safe, appropriate, consistent and effectively monitored. This was evidenced by the following findings:

- The systems of monitoring residents' individual assessment and care planning records did not identify significant gaps which posed immediate risks to residents. This is discussed further under Regulation 5: Individual assessment and care plan.
- As outlined under Regulation 16: Training and staff development, significant gaps in staff training records demonstrated inadequate oversight of staff training needs and practices. For example; in the IPC audit dated April 2025 a finding included that staff need clinical waste training. The same finding was made in the subsequent audits in July 2025 and October 2025.
- A recent audit of skin integrity and wound care had a compliance score of 49%. The only resulting actions were that staff nurses were to update the residents' care plans. This was a missed opportunity to fully analyse the findings of the audit and identify trends that require improvement. Multiple audits of residents' skin integrity and wound care showed consistently low scores, and no targeted QIP was devised to ensure that compliance increased.
- There were ineffective management systems to monitor the quality of infection prevention and control measures including equipment storage, toiletries and laundry storage. An audit finding in October 2025 found that bathrooms should not be used for storage. However, this practice was observed by inspectors to be still occurring during the inspection.
- Staff, management and resident meetings were taking place regularly but in some cases agenda and quality improvement plans were missing. This could lead to specific IPC concerns not being raised or discussed and was a lost opportunity for improvement outcomes.
- Multi Drug Resistance Organism (MDRO) surveillance was not sufficinetly comprehensive and required more detail to identify and close gaps in infection control and containment.
- Various strategies were in place to ensure appropriate use of antimicrobial medications, aiming to mitigate the risk of antimicrobial resistance. These measures included monthly monitoring. However, there was little analysis of antibiotic usage in terms of volume, indication, and effectiveness. This

information will help inform quality improvement plans to maximise the benefit of antimicrobial therapy.

Judgment: Not compliant

Quality and safety

Overall, residents had a good quality of life in the centre, but significant safety concerns were identified in respect of assessment and care planning and infection control as further outlined under their respective regulations. Inspectors were assured that there was a positive ethos of care and support, that residents were supported to live their lives to the fullest extent and staff respected each resident's individual human rights.

The centre had arrangements in place to ensure that visiting did not compromise residents' rights, and was not restrictive. Residents were able to meet with visitors in private or in the communal spaces throughout the centre. Residents had timely access to their general practitioners (GPs) and specialist services such as psychiatry of later life and consultant geriatricians as required. There were pathways for referral to and review by other health and social care professionals such as speech and language therapy, dietitian and chiropody.

Prior to admission, residents were assessed to determine if the centre could meet their individual needs. An IPC assessment formed part of the pre-admission records. The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to hospital. This document contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services. A review of residents' records including clinical assessments and care plans identified mixed compliance with the regulations. For example, some residents had detailed and personalised care plans that were based on their assessment. However, significant gaps were observed in some records, which provides unnecessary risk to residents' welfare. This is discussed further under Regulation 5: Individual assessment and care plan.

Staff were observed to apply standard precautions to protect against exposure to blood and body substances during handling of sharps, waste and used linen. The provider had substituted traditional needles with a safety engineered sharps devices to minimise the risk of needle stick injury. Colour-coded laundry trolleys and bags were brought to the point of care to collect used laundry and linen. Appropriate use of personal protective equipment (PPE) was observed and all staff were bare below the elbow to facilitate effective hand hygiene practices.

The current housekeeping facilities on the ground floor are of insufficient capacity to accommodate essential equipment. The practice of transporting and storing both

cleaning trolleys in the upstairs housekeeping room introduces a risk of cross-contamination between the two floors cleaning trolleys.

A review of the management of residents' rights during an outbreak found that measures taken to protect residents from infection were appropriate and proportionate with the assessed level of risk. For example, staff explained that restrictions put in place to manage the outbreak were proportionate to the risks of infection. Individual residents were cared for in isolation when they were infectious, while social activity and visits continued for the majority of residents during the outbreak. Residents were consulted with formally through residents' meetings, which were well-attended, and through satisfaction surveys. Informal conversations and check-ins by management and staff ensured that residents were also consulted with on a daily basis.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were not restrictive, and there was adequate private space for residents to meet their visitors. The updated visiting policy outlined the arrangements in place for residents to receive visitors and included the process for normal visitor access, access during outbreaks and arrangements for residents to receive visits nominated support persons during outbreaks.

Judgment: Compliant

Regulation 17: Premises

The premises did not fully conform to the matters set out in Schedule 6 of the regulations:

- The available floor space for each resident in one twin bedroom did not allow for the space occupied by a bed, a chair and personal storage space. There were built-in wardrobes at one end of the room and the layout of the room was such that the two beds were confined to an area which had a width of three metres, this meant that only one locker could fit between the two beds.
- Some areas of the centre required decoration due to wear and tear. Inspectors observed some floors and walls required upgrade and repair to ensure they could be effectively cleaned to prevent the risk of cross infection.
- The downstairs housekeeping room was too small to accommodate the cleaning trolley, resulting in it being stored in the upstairs cleaning room alongside the upstairs trolley. This mixing of equipment from different areas presents a risk of cross-contamination.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Where the resident was temporarily absent from the designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the *National Standards for infection prevention and control in community services* (2018), however further action is required to be fully compliant. This was evidenced by:

- Barriers to effective hand hygiene practice were observed during the course of this inspection. For example additional dispensers or individual bottles of alcohol hand gel were required to ensure alcohol hand gel was readily available at point of care. There were a limited number of HBN 00-10 Part C compliant clinical hand-wash sinks available for staff use.
- Sharps boxes were seen with temporary closure mechanism not in place, and not signed. If a bin is knocked over or dropped, an open lid allows contaminated needles to spill out, creating an immediate needlestick injury risk for staff and residents.
- Dressing trolleys were already prepared and stocked with items required for dressings. This posed a risk of contamination of the sterile supplies on these trolleys.
- Single-use wound dressings were found stored in open packaging. This practice compromises the sterility of the product and poses a risk of introducing infection to resident wounds.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents' individual assessment and care planning records. This review identified a number of findings which were not in line with the requirements of the regulation.

The registered provider did not always arrange a comprehensive assessment of the needs of a resident immediately before or on admission to the centre and did not consistently prepare a care plan for the resident within 48 hours of the residents' admission to the centre. For example,

- There was no record of clinical assessments having been carried out for a resident who had been admitted seven weeks previously. This was despite the presence of multiple risk factors, including the presence of a significant wound. Additionally, this resident had no care plans in place to direct their specific care needs, including serious medical conditions which required consistent monitoring and medical and nursing input.

Care plans were not always reviewed within the required four month intervals:

- A resident with a known elopement risk had not had their risk assessment or care plan updated for six months.
- A resident's mobility status had changed significantly, however their personal emergency evacuation profile (PEEP) assessment, and the associated care plan, had not been updated to reflect this change.

In addition, some current care plans lacked the prescriptive detail required to consistently direct safe care. For example: catheter care plans did not detail the scheduled change dates for catheters and wound care plans did not detail the most up-to-date dressings as advised by specialist wound care nurses.

An immediate action plan was issued to the registered provider in respect of the management of wounds and required pressure relieving equipment for a particular resident to ensure their safety. This action was completed by the end of the inspection.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a GP of their choice. Residents also had access to a range of health and social care professionals such as physiotherapy, dietician and tissue viability nursing.

Judgment: Compliant

Regulation 9: Residents' rights

The principles of a human rights-based approach were central to the ethos of the centre. Residents rights were upheld and care and support was delivered in a person-centred and respectful way. There was independent advocacy services made available to all residents and their contact details displayed around the centre Residents were encouraged to maintain links with their community, friends and families. Residents were kept up-to-date with current and foreign affairs through access to media including local and national newspapers, radio, television and Internet services

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Brabazon House OSV-0000017

Inspection ID: MON-0049061

Date of inspection: 04/02/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Mandatory Training and additional trainings are arranged for all clinical staff as well as Ancillary staff such as laundry staff, maintenance and administrative staff are also included in training Matrix. The Training Matrix has been examined and updated to establish a comprehensive framework for identifying staff training deficiencies across all disciplines. An administrative staff is now assigned to work collaboratively with the PIC to keep this regulation in full compliance to ensure the staff in the designated centre demonstrate full compliance with the training principles into practice Staff meeting was completed to highlight these gaps	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Regulation 5 and Regulation 16 reference the action plan outlined in the specified compliance plan. Clinical Nurse Managers (CNMs) were briefed by the Person in Charge (PIC) concerning	

the auditing process and are currently collaborating with an external clinical guidance provider to train the two Clinical Nurse Managers in the appropriate audit tools and feedback protocols aimed at enhancing compliance levels to fulfil the Quality Improvement Plans.

Consult regulation 27 box for the compliance plan.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Maintenance Personnel and the health and safety committee performed a risk assessment and are looking into solutions to adhere to this regulation, such as installing narrower lockers to fit between the bed spaces in room 015, which currently accommodates two beds and two bed side lockers.
The PIC and General Manager organised a meeting with the housekeeping staff, property manager, and maintenance personnel to discuss the cleaning process, deep cleaning checklists, decluttering, and the enhancement of areas and furnishings needing decoration in communal spaces and individual residents' bedrooms to prevent the risk of cross-infection. The audit report is created to implement the action plan for the identified defects.

The property manager, general manager and the person in charge have investigated the possibility of repurposing the janitorial sink in the cleaner's room 014 (ground floor). The equipment will be replaced with appropriately sized sink, the room will be decluttered to facilitate the proper arrangement of housekeeping cleaning tools and supplies, and measures will be taken to prevent the mixing of equipment from other areas to avoid cross-contamination.

The external contractor will confirm refresher IPC training, chemicals management, and outbreak control procedures and protocols for housekeeping staff members, with a timeline determined by the PIC.

Regulation 27: Infection control	Substantially Compliant

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

The PIC, IPC lead nurse, and the health and safety committee conducted an environmental audit and a walkabout to assess the quantity of alcohol hand dispensers and moisturiser dispensers present. The external service provider has been informed to implement changes and supply a designated dispenser for the identification of alcohol hand gel, soap dispensers, and moisturising gel.

The PIC, IPC lead nurses and the health and safety committee looked into the potential installation of a clinical hand wash sink for staff use in the Lower Pax area corridor, ensuring compliance with HBN 00-10 Part C standards.

The training on waste segregation for the care team and staff nurses is ongoing via HSE land, while the IPC link nurse is supervising the training on needle stick injuries. The ongoing initiatives focus on enhancing staff knowledge regarding infection prevention and control, waste segregation, and the management of needle stick injuries and wound dressings. Policies are reviewed and has been sent to staff to refresh with the designated centre's protocols. A specific area has been allocated in the treatment room on the ground floor for the storage of the filled sharps container, complete with a closure label, and this has been included in the weekly clinical equipment checklist. Safety needles were purchased and in use now. The protocol will be overseen by the PIC and the duty CNMs.

A clearly defined dressing trolley is positioned near the nurses' station, and a centralised inventory for dressings has been established to guarantee that all items are properly labelled. After each use, dressings will be discarded to mitigate the risk of contamination. Signage is provided for nurses to ensure that resident-specific dressings are labelled and have a designated storage space.
A refresher training session has been arranged for the IPC link nurse to enhance their understanding of the IPC auditing procedure. This initiative aims to identify and address deficiencies for auditing process such as, antimicrobial audits, performing Multi Drug Resistance Organism (MDRO) surveillance audits, executing root cause analyses, ensuring uniformity in audit feedback, and formulating action plans to improve the quality of care for residents, thereby strengthening compliance with this regulation.
Eternal clinical guidance provider will review IPC practices on site in April 2026.

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:
Nurses' meeting was convened to emphasise the significant non-compliance identified in this report.

Work performance appraisals have commenced to emphasise nurses' clinical competency and the management of residents' care plans, ensuring timely formulation and input of assessed risk and care plans. Refresher training on care plans has been organised for all nurses.

Clinical nurse managers are now designated to review daily assessments and care plan records in the electronic system to ensure that the day's caseload updates are executed by the day and night nurses on duty.

The care plan allocation for individual nurses has been revised. Admissions care plans will be finalised within 48 hours.

To comply with this regulation, the PIC is overseeing the care plan review to ensure that nurses are effectively communicating and collaborating with residents, their representatives, and the multidisciplinary team. This oversight guarantees that assessments are conducted, followed by the implementation of appropriate person-centred care plans based on the assessed risks for each individual resident

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.	Not Compliant	Orange	30/06/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2026
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	30/11/2026

	effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	30/04/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/04/2026
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	30/04/2026
Regulation 5(4)	The person in charge shall formally review, at	Not Compliant	Orange	30/04/2026

	intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			