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:	Brookhaven Nursing Home
Name of provider:	Brookhaven Nursing Home Limited
Address of centre:	Donoughmore, Ballyraggett, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	24 September 2025
Centre ID:	OSV-0000207
Fieldwork ID:	MON-0048230

About the designated centre

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

Brookhaven Nursing Home is situated in the village of Ballyragget, seven kilometres from the town of Durrow, Co. Kilkenny. The centre is registered to accommodate 71 residents, both male and female. It is a two-storey building but resident's accommodation and facilities are located on the ground floor; the staff changing facilities are located upstairs. Residents' accommodation comprises of single and twin bedrooms with en-suite shower and toilet facilities, two dining rooms, an activities room, sitting rooms and a sun room. There are comfortable seating alcoves throughout the centre and toilet facilities are strategically located for residents' convenience. Residents have access to five enclosed garden areas with seating and walkways. Other facilities include the main kitchen and a laundry. Brookhaven provides full-time nursing care for people with low to maximum dependency assessed needs requiring long-term residential, palliative, convalescence and respite care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	67

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 24 September 2025	14:00hrs to 18:45hrs	Mary Veale	Lead
Monday 29 September 2025	10:00hrs to 18:30hrs	Mary Veale	Lead
Wednesday 24 September 2025	14:00hrs to 18:45hrs	Laura Meehan	Support
Monday 29 September 2025	10:00hrs to 18:30hrs	Laura Meehan	Support
Monday 29 September 2025	10:00hrs to 18:30hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. The first day of inspection was an afternoon inspection carried out by two inspectors. Three inspectors returned five days later for the second day of inspection.

Over the course of the inspection the inspectors spoke with many residents, staff and visitors to gain insight into what it was like to live in Brookhaven Nursing Home. The inspectors spent time observing the residents daily life in the centre in order to understand the lived experience of the residents. Inspectors spoke in detail with 15 residents and three visitors. Residents and visitors expressed concerns relating to the centre being short-staffed, the lack of staff supervision, and that the centre was cold, in particular some bedrooms and communal areas. A number of residents told the inspectors that there was a shortage of bed sheets and that sometimes blankets or duvet covers were used to cover the mattress as a substitute for sheets. At the time of the inspection, an outbreak of scabies had been declared in the centre. The outbreak was mainly confided to Kilminan wing and an isolated case in Attanagh wing.

Brookhaven Nursing home is located on the outskirts of the village of Ballyraggett in Co.Kilkenny. The centre is a two-storey building. The centre was registered to accommodate 71 residents. The first floor of the building is not registered as part of the designated centre. The first floor contained the centre's administration office and staff changing facilities. The location, design and layout of the centre was generally suitable, however aspects of the premises were not appropriately equipped and used in line with their designated purpose, as further described in the report. The outdoor spaces included inner courtyards from each wing, which were readily accessible and safe, making it easy for residents to go outdoors independently or with support, if required.

Throughout the two inspection days, small groups of residents were observed sitting in the day room on Attanagh wing, some having their meals in the dining room. In contrast, the inspectors observed that the residents in Kilminan wing were mostly confided to their bedroom. A significant number of residents were observed wearing their night attire on corridors and communal areas throughout the inspection days.

Residents had access to a large reception area, three dayrooms, two large dining rooms, a lounge, a conservatory, sitting room, an oratory, a visitors room, an aromatherapy/relaxation room and a hair salon. Two day rooms and the conservatory were not accessible to residents on both days of inspection. The oratory and relaxation/aromatherapy rooms were not available to residents on the first day of inspection. The premises are discussed in further detail under Regulation 17: Premises. The centre's production kitchen, laundry,staff canteen, and maintenance rooms were situated to the rear of the centre. There was an indoor smoking room available to residents.

A strong smell of urine was detected in parts of the centre on both days of inspection. Ancillary facilities did not support effective infection prevention and control. The sluice room on Kilminan wing was observed in use as a store room and the bedpan washer had been removed from this room. There were three sluice rooms for the reprocessing of bedpans, urinals and commodes. On the morning of the second day of inspection there were no bedpan washers working in the centre. By the end of the second day there was one bedpan washer working in the centre.

Laundering of residents' clothing and bed linen was provided on-site and some residents chose to have their clothing laundered at home. The inspectors observed that not all residents' clothes were marked to ensure they were safely returned from the laundry. Cleaning textiles were laundered in a domestic washing machine in the on-site laundry. Inspectors observed that residents who were affected by the outbreak of scabies did not have their clothing managed appropriately. This is discussed further under Regulations 12: Personal possessions and Regulation 27: Infection prevention and control.

Improvements were required in respect of premises and infection prevention and control, which are interdependent. For example, floor surfaces and finishes including wood finishes around doors and flooring in some resident rooms and on corridors were worn and damaged and as such did not facilitate effective cleaning. The Oak dining room, the toilets adjacent to this dining room and some ancillary facilities including the laundry and clinical rooms did not appear to be maintained to the same standard of cleanliness as the other areas. The inspectors observed two yellow bins on a corridor on Attanagh wing that created a narrowing of the floor space on the corridor which the residents had to navigate. Findings in this regard are further discussed under Regulation 27: Infection prevention and control.

Residents had access to a timetable of activities which were facilitated by activity staff. On the first day, the inspectors observed approximately 15 residents in the large dayroom on Attanagh wing waiting to watch a movie. There were difficulties accessing the movie platform so an alternative movie was shown which was not appropriate to the audience. Some residents told inspectors they did not enjoy the movie shown. The room was not set up as a comfortable, relaxed setting that provided an appropriate space for residents to enjoy a cosy and fun experience.

On the afternoon of the first day of inspection, the television was not working in the sitting room of Rosconnell wing. On the second day of inspection, inspectors observed a bingo session in the Ash dining room. Some residents were still eating their lunch time meal while the bingo session was taking place, which was disruptive and did not ensure a dignified mealtime experience for the residents. A number of residents were supported to dine in the activity room resulting in this room being inaccessible to other residents.

Residents had access to radios, televisions, and newspapers. Mass was live-streamed in the centre daily. Access to independent advocacy was available. The centre was also home to Maggie, the dog. Residents spoke fondly of Maggie, and she was observed visiting residents in their bedrooms and communal areas.

The inspectors observed the dining experience at dinner time on the second day of inspection and saw that there were two separate sittings for dinner. The residents who required assistance had their meal in the dayroom on Attanagh wing and the resident's who were independent had their meal in the Ash dining room. The Oak dining room was not observed in use on any inspection days. The inspectors observed that the meals provided appeared appetising and were served hot. Most residents were complimentary about the food and confirmed that they were always afforded choice and provided with an alternative meal should they not like what was on the menu. Adequate numbers of staff were available and were observed offering encouragement and assistance to residents. A significant number of residents in Donoughmore and Rosconnell wings had their meals in their bedrooms. Residents in Kilminan wing who were isolating due to the scabies outbreak had their meals in their bedroom.

Visitors whom inspectors spoke with were generally complimentary of the care and attention their friends/relatives received. However, a visitor acknowledged there had been aspects of service provision that required improvement and that their family had met the person in charge to deal with these issues.

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

Capacity and capability

This unannounced inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 to 2025 (as amended), and to follow up unsolicited and solicited information received by the Chief Inspector, pertaining to serious incidents notified, safeguarding, residents' rights, the quality of care, including health care provided to residents living in the centre. This information was used to support the development of lines of enquiry and was substantiated on this inspection.

This inspection found a marked decline in the level of regulatory compliance for this centre. Significant improvements were required in the oversight and management of the service to ensure safe effective systems were in place to support and facilitate the residents to have a good quality of life. Following the first day of inspection, an urgent compliance plan was issued to the registered provider in respect of the premises, infection prevention and control IPC) and medication management. Satisfactory assurances were not received to this urgent compliance plan and a second day of inspection took place. Following receipt of the provider's response to the urgent compliance plan and the findings on the second day of inspection, a second urgent compliance plan was issued to the registered provider requesting assurances regarding the mitigation of risks associated with the premises, poor

governance and management of the centre, infection prevention and control, as well as medication management. Again this response did not provide adequate assurances.

Due to the significant concerns about the governance and management of the centre, a warning meeting was held where the provider was informed that escalation measures will be taken, which may include the attachment of additional conditions to the registration of Brookhaven Nursing Home should compliance with the Health Act 2007 not be achieved in a timely manner to ensure the safety and well being of residents in the centre.

Brookhaven Nursing Home Limited is the registered provider for this centre. At the time of inspection there were four directors in the company. The centre is part of a group of five nursing homes and had access to group resources, such as; finance, human resources and facilities management. The person in charge (PIC) had a team consisting of an assistant director of nursing (ADON), a clinical nurse manager (CNM), registered nurses, health care assistants, kitchen staff, housekeepers, activities staff, administration and maintenance staff. However, there had been recent changes to the operational management team, with new ADONs and CNMs appointed to the role in August 2025.

The inspectors found that the staffing and skill mix on the days of inspection were not appropriate to meet the care needs of residents. This is discussed further under Regulation 15: Staffing.

Further action was required to ensure that all staff had access to appropriate training and were appropriately supervised. The provider had not ensured the person nominated to the role of infection prevention and control (IPC) link practitioner has received sufficient training to support staff to implement effective IPC and antimicrobial stewardship practices within the centre. This is discussed further in this report under Regulation 16: Training and staff development.

There was poor oversight and inadequate management systems to monitor the centre's quality and safety. There was evidence of an ongoing schedule of audits in the centre, including the areas of infection prevention and control, falls, care planning and medication management audits. Audits identified improvements and had action plans developed. However, action plans were not followed up and did not lead to any improvements or changes in practices, as inspectors saw that the findings identified in the audits were similar to findings of the inspection. Despite requesting them, the inspectors were not provided with any records of governance meetings on inspection. Instead governance reports were provided to the inspectors. Staff meeting minutes were reviewed and found to be brief, repetitive and did not show evidence of discussion or sharing the learning and the action plans arising from audits to drive quality improvement.

At the beginning of the second day of inspection, the inspectors provided a documentation list to the person in charge requesting that these documents be made available. A number of documents on this list were requested several times

during the day and were not provided in a timely manner. This is discussed further under Regulation 23: Governance and management.

There was a record of accidents and incidents that took place in the centre. Most notifications were submitted appropriately to the Chief Inspector. However, following a serious incident, some monitoring notifications had not been identified which required submission to the office of the Chief Inspector. This is discussed further in this report under Regulation 31: Notification of incidents.

Regulation 15: Staffing

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

- Short-term absences were not replaced. On the first day of inspection two staff were on unplanned leave and three staff were absent on the second day of inspection. These shifts were not filled on both days and no evidence or assurance was submitted that the provider had tried to acquire agency staff cover. Staff informed the inspectors that this was a regular occurrence and that unexpected leave would frequently occur.
- Residents told the inspectors that the centre was often short-staffed, particularly during weekend day shifts.
- Staffing was not in line with the registered statement of purpose. A second activities staff member was not working in the centre, which meant that there were days when activities were not provided to all residents.

The shortage of staff was observed to adversely impact residents in the centre leading to delays in care and residents' not being provided with care in line with their preferences and assessed needs. For example:

- Inspectors observed a resident who had to wait over 15 minutes to be assisted to the bathroom, despite the call-bell being activated by staff to gain support.
- One resident told the inspectors that the staff informed her they were short staffed on the morning of the second inspection and would not have time to give her a shower that morning but would return later at 3pm. The resident confirmed with the inspectors that the staff never returned to give them a shower at 3pm.
- Activities were not being provided as scheduled due to insufficient staff.

Judgment: Not compliant

Regulation 16: Training and staff development

Not all staff had access to appropriate training to support them to perform their respective roles. For example, eight staff required training in safeguarding, managing behaviours that are challenging, fire safety and infection prevention and control. In addition there was no evidence provided to inspectors of staff having attended refresher manual handling training in early September 2025 as outlined in correspondence received from the provider relating to a serious incident.

Staff were not adequately supervised to ensure they implemented local policies and procedures and adhered to best evidence practice in respect of upholding residents' rights and providing safe care and reducing the risk of harm to the residents. For example:

- There was evidence of incorrect practices in the area of infection prevention control, including the poor management of an outbreak of scabies and poor adherence to hand hygiene and personal protective equipment (PPE) practices.
- Over the two days, improper practices were observed in the storage, administration and stock control of medications and medicinal products.
- During the inspection, staff were observed to use personal phones when supporting residents.

Judgment: Not compliant

Regulation 23: Governance and management

Over the course of the inspection, due to significant risks identified by inspectors a number of immediate actions were issued to the provider, including the receipt of emergency medication for epilepsy and storage of medication. These were addressed on the day.

Furthermore, other significant care and welfare concerns in respect of the quality and safety of the care and service provided. This resulted in the provider being issued an urgent action under:

- Regulation 17: Premises
- Regulation 23: Governance and management
- Regulation 27: Infection prevention and control and,
- Regulation 29: Medicines and pharmaceutical services.

The provider's responses to the urgent compliance plan did not assure the chief inspector that appropriate measures were put in place to mitigate the risk.

The registered provider had failed to ensure that the centre was adequately resourced to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- Short-term staff absences were not replaced in a timely manner to ensure residents' needs were met in line with their individual assessments. This occurred on a frequent basis as confirmed by residents and staff and was observed on both days of inspection.
- The centre did not have sufficient stocks of linen and bed sheets at the time of inspection.
- Areas of the centre were not adequately furnished to support the residents. for example there was no furniture in one of the living rooms to be used by residents. Some furniture was delivered on the second day of the inspection.
- There was only one activity staff in the centre at the time of inspection, despite the centre being registered with a minimum of two whole time equivalents for the provision of meaningful occupation.

The management systems in the centre were inadequate and not effective at ensuring the service provided was safe, appropriate, consistent, and effectively monitored. For example:

- The provider had failed to recognise, respond to and manage serious incidents within the centre. An effective investigation and review was not completed following the occurrence of a serious incident within the centre. As a result, there was no learning from serious events and no action plans to address areas of risk.
- There was lack of maintenance and proactive management of premises and facilities to ensure a safe environment at all times. The provider was aware of faults and concerns in respect of the heating system in the centre dating as far back as May 2025. Nevertheless, a number of radiators were not working on the days of inspection and residents and visitors reported that they were cold. Staff were not aware of the arrangements for the reporting and escalating of maintenance issues.
- The systems for oversight and monitoring residents' care planning arrangements and care delivery had failed to identify significant gaps in care records and did not provide assurance in respect of the standard of care that residents received.
- The oversight of staff practices was poor and there was a lack of assurance that staff were familiar with local policies as numerous examples were seen of staff failing to implement local policies in practice. This included the use of mobile phones, management of complaints, documentation management.
- The centre was not adequately clean in all areas and infection control practices, including the management of scabies was poor. There was poor management and oversight of stock controls of dressings and laboratory blood collection containers, as further detailed under Regulation 27.
- The oversight and monitoring of incidents and accidents was inadequate. There was a failure to recognise and notify the chief inspector of all reportable incidents in line with regulatory requirements. This is discussed further under Regulation 31: Notification of Incidents.
- The audit systems were ineffective at identifying risks and driving quality improvements. For example: A medication management audit carried out in June 2025 evidenced 42% compliance. An action plan had been developed on

paper, however, three months later, the findings of this inspection showed no improvement in any of the identified areas.
- Information governance systems in the centre were inadequate. Records requested for inspection were not provided in a timely manner. When records were made available, they were found to be of poor standard.

The provider was in breach of condition 1 of their registration certificate which required them to provide services within the facilities agreed at the time of registration. The provider was found to have removed a sluice facility in Kilminan wing, and the room was observed as a store room on inspection. This was not appropriate and had not been communicated to the Office of the Chief Inspector.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the records in relation to a serious incident in the centre showed that there were four incidents as set out in Schedule 4 of the regulations that were not notified to the office of the Chief Inspector within the required time frames. The provider submitted these notifications retrospectively following the first day of inspection at the request of inspectors.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had not ensured complaints were managed in accordance with the timelines set out in the providers policy and regulatory requirements. For example; one resident had been informed a response would be completed to their complaint within 28 days as set out in the centres complaints policy. This had not been completed at the time of inspection, which was 31 days following receipt of complaint nor had the complainant been updated as to when they could expect a response.

Records provided to inspectors did not allow for a full review of complaints.

- One resident spoken with was not aware of the complaints process and despite discussing their concerns with staff, no complaint had been logged and the complaints policy had not been adhered to.
- One family informed the inspectors that a written complaint had been submitted to the provider in March 2025. This was reiterated in a report forwarded to the inspectors by the provider. No complaint record was available for review.

Judgment: Not compliant

Quality and safety

Inspectors found that residents living in Brookhaven Nursing Home did not receive a good standard of care and the registered provider did not take all measures to ensure their health and social care needs were being effectively met. Poor oversight and management, as discussed in the Capacity and Capability section, adversely impacted on the safety and quality of life for the residents living in the centre. The findings of this inspection are that significant action and renewed focus was required to come into compliance with care planning, health care, safeguarding, resident's rights, premises, infection control and prevention, and medication management.

The inspectors viewed a sample of residents' notes and care plans. Overall the standard of care planning required improvement to ensure that they were accurate and updated to guide safe and effective care. Details are presented under Regulation 5: Individual assessment and care plan.

Residents had access to general practitioners (GP) from local practices, specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, dietitian and speech and language, as required. Residents had access to a mobile x-ray service referred by their GP which reduced the need for trips to hospital. Residents had access to local dental and pharmacy services, however access to tissue viability nurse was only available remotely. Residents who were eligible for national screening programmes were also supported and encouraged to access these. Despite having access to these services, further improvements were required in healthcare. This is discussed further under Regulation 6.

Management of premises and residents' personal possessions was not adequate as further discussed under Regulation 12: Personal possessions and Regulation 17: Premises.

An ongoing scabies outbreak in the centre was likely exacerbated by several infection prevention and control failures, including the lack of resident isolation when symptomatic, unclear guidance for staff, improper management of laundry and non-washable items as well as potential errors in the application and administration of treatments. These gaps contributed to continued transmission and highlight the need for enhanced staff training, standardised procedures and improved oversight of infection prevention and control procedures. Details of issues identified are set out under Regulation 27.

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications. A pharmacist was available to residents to advise them on medications they were receiving. However; actions were required in respect

of storage, documentation and administration of medications as further outlined under Regulation 29: Medicines and pharmaceutical services.

An activity schedule was in place and activities were available from Monday to Sunday. Inspectors observed mixed practices in respect of engagement of residents in meaningful activities as described in the first section of the report. Areas for action were identified to ensure that all residents in the centre could exercise choice which did not interfere with the rights of other residents.

Regulation 12: Personal possessions

The person in charge had not ensured that residents had access to and retained control over their personal property. For example:

- Residents' belongings were stored upstairs in part of the building which was not part of the registered centre and where residents could not access them.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider did not ensure the premises of the designated centre were appropriate to the needs of the residents and in line with the statement of purpose. For example:

- Staff were observed to utilise resident communal spaces for meal breaks, despite a staff break facility being available.
- Staff were also observed to use one residents' living room for the duration of the day two of the inspection for interviews. This meant that facilities registered for residents' use were not available to them at all times.
- Two day-rooms and the conservatory were not accessible to residents on both days of inspection.
- The oratory and relaxation/aromatherapy rooms were not available to residents on the first day of inspection.
- The sluice room on Kilminan wing was being used observed as a store room.

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example, but notwithstanding;

- Parts of the centre required repair to ensure they could be effectively cleaned. For example: floors in the staff room, smoking room and bedroom areas were damaged.
- There was no system for adjusting or recording the temperature in the centre. Areas of the centre were cold, and the residents and visitors told

inspectors that this was a long standing issue and was reported by residents and visitors. The dayrooms and conservatory near the reception, the oratory, relaxation/aromatherapy rooms, corridor areas, and bedrooms on Rosconnell and Donoughmore wings were cold.

- The temperature of water in the hot taps in the visitors toilet and some residents' en-suite toilets was very hot creating a risk of burns for anyone using these facilities.
- Not all areas were appropriately furnished and parts of the centre did not provide a homely environment. There was insufficient seating in a number of communal rooms. For example, the visitors' room had one chair and a table. Also, one sitting room did not contain any furniture until 2pm on the second day of inspection, five days after this was highlighted to the management team.
- Residents were observed to be smoking in non-designated smoking areas, such as doorways and as a result there was a strong smell of cigarette smoke in a number of corridors.
- There were inadequate functioning sluicing facilities within the centre on both days of inspection. None of the bedpan washers were in working order.
- There was inappropriate storage and hoists were observed stored haphazardly on corridors increasing the risk of falls for residents.
- Not all facilities were appropriately equipped. For example the housekeeping room did not have a hand wash facility.
  Not all equipment to be used by residents was in working order. For example a television in a residents' living room was not working.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not meet the regulatory requirements and the National Standards for infection prevention and control in community services (2018). For example:

- In the absence of a hand wash basin in the housekeeping room, there was a lack of assurance that housekeeping staff performed hand hygiene at the point of use.
- Clinical waste bins in the centre were not enclosed and pedal operated for the the safe disposal of potentially contaminated items, such as used PPE and wound dressings.
- Clothing belonging to some residents was stored on the floor of the laundry and on a carpeted floor in an upstairs store room creating a risk of contamination.
- A domestic washing machines was used to wash used mops and cleaning cloths. As a result, inspectors were not assured that correct thermal disinfection temperatures were reached to ensure that these textiles were washed at the correct temperature.

- There was inappropriate storage practice in some store rooms which could result in cross contamination. For example: mattresses, hoist slings, PPE's and decorations were all stored together and on the floor.
- Room disinfection was not effective because the rooms were not cleaned first to remove organic matter, dirt, and grime, which can reduce the effectiveness of any disinfectant subsequently used.
- Inspectors observed poor hand hygiene practices.
- Cleaning records showed that deep cleans of rooms were not scheduled, and there was no system to ensure deep cleaning at regular intervals.
- Outbreak documentation was not clear, dates were written down incorrectly and the outbreak line list was not easy to follow.
- PPE stations were still in place despite residents having received multiple treatments for scabies. This was not in line with guidance and the overuse of PPE can negatively impact on resident's care, rights and can increase resident isolation.
- A damaged mattress had not been replaced but repaired with tape. This was not appropriate.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Practices observed in relation to the storage and use of some medications were not in line with best-practice medicines guidance. For example;

- Medications were stored inappropriately in an unsafe manner. For example, prescribed topical medication was found in residents bathroom with the lid open and food supplements were found in unlocked press in communal area.
- Medicines that were no longer required were not segregated from other medicinal products and disposed of in accordance with national legislation. These were found to be stored in a paper bag on a counter in a treatment room.
- Out of date medication was found in the control drug press on Kilminan wing. Inspectors requested an immediate assurance on the first day of inspection that in date medication was obtained for the resident who was prescribed the medication.
- Medication for use in the treatment of scabies was not always administered in line with prescriber's directions
- There were inaccurate records for the administration of prescribed medication i.e. eye drops and the medication used for the treatment of scabies.
- Nurses were not adhering to best practice procedures when counting control drug medications.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- Some individual assessments were found to be inaccurately recorded or not fully completed, therefore, they could not inform care delivery. For example, a resident who was lactose intolerant had a care plan outlining a high protein diet which included milk, cheese, butter and cream.
- Care plans required review to ensure a specific and person-centred approach to care was provided. A sample of care plans viewed were not sufficiently detailed or person centred to guide staff on the care of residents. Of the sample of care plans viewed, many were generic with pre-populated interventions which were not reflective of the needs of the individual resident's.
- Discrepancies were found between the care plans and the progress notes for a number of mobility care plans for residents. For example; care plans outlined clear instructions on the type of mobility equipment to use to assist in the mobility of residents but the progress notes documents stated there wasn't use of manual handling equipment in the turning of residents.
- There was inconsistent guidance for staff on the support needs for residents including in the area of manual handling. For example, one resident's plan stated two staff required for transfers, in the next paragraph it stated one staff for support**.**
- Care was not always provided in line with residents' assessed needs and preferences as outlined in their care plan. There were residents who were still wearing their night attire in the afternoon and who had not had their personal needs attended to due to insufficient staffing levels.
-

Judgment: Not compliant

Regulation 6: Health care

The registered provider did not ensure that all resident had appropriate access to medical and health care. For example:

- A number of residents who were known to have epilepsy and had previous seizures did not have an epilepsy protocol that provided details of health and medical information about an individual and their epilepsy or seizure disorder. Lack of clear guidance to direct staff on the management of seizures may lead to delayed or incorrect responses to seizures and increase the risk of injury to residents.

- There was insufficient guidance for staff in the management of fractures. For example, one resident sustained a fracture in March 2025. It was unclear at the time of the inspection if the fracture had healed or what measures were required for support.
- Where staff stated a resident was at high risk of fractures, this was not documented and there was no clear guidance from the multidisciplinary team on actions to implement to reduce the risk.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured that all reasonable measures were implemented to protect residents from abuse. Following a serious incident adversely impacting residents' care, the person in charge failed to carry out a comprehensive investigation to fully investigate the incident including any potential misconduct of staff.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' right to exercise choice was not always upheld by the registered provider. For example;

- Facilities for occupation and recreation were not available to the residents on the days of inspection. These included the two day rooms and conservatory near the reception area, oratory and the relaxation rooms. Some of the communal rooms that were available were not in use by the residents to support group activities and social engagement.

There was a lack of meaningful activities available for residents in the centre, which meant that, for the most part, residents were not participating in activities of interest to them. For example:

- Many residents were seen to be sleeping in chairs or sitting in front of the TV with little stimulation and engagement, throughout the days of inspection.
- Records available did not demonstrate a high level activities within the centre and were not consistently recorded.
- The activity schedule on display in one area was dated July 2025 and did not provide updated information for residents.The activities displayed did not match the activities provided on the day. This meant that residents did not

know in advance what activities were on offer to exercise choice in respect of what their preferred to attend.

- There was one activity staff member on duty on the days of inspection who was observed providing scheduled group activities. Residents that remained in their bedrooms or required enhanced supports such as 1 to 1 stimulation were not provided with any stimulation during the inspection.
- Inspectors were not assured that residents could exercise choice in relation to their preferred routines. The majority of residents were in bed when inspectors arrived at the centre around 10am. Resident were seen asking for support for assistance to the toilet or going to bed, and there were insufficient staff to support them at the time of the request.

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 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Brookhaven Nursing Home OSV-0000207

Inspection ID: MON-0048230

Date of inspection: 29/09/2025

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:
The registered provider acknowledges the staffing deficits identified during the inspection. While full staffing levels have not yet been achieved, significant actions are underway to ensure that the centre will have the appropriate number and skill mix of staff to meet residents' assessed needs and the layout of the centre.

A revised process is now in place for managing unplanned leave. All short-notice absences are escalated immediately to the PIC and HR, who are required to contact all contracted agency providers to source cover. All attempts to secure replacement staff are now being documented.

Although not all shifts have been successfully filled to date, active efforts are being made daily, and this will continue until reliable cover is secured.

The agency provider has committed to supplying the same consistent agency staff for the next three months, supporting continuity of care and increased stability during the recruitment phase.

Recruitment is ongoing to address current staffing gaps. A total of eight healthcare assistants (HCAs) are due to commence employment shortly, which will significantly strengthen the staffing complement and reduce reliance on agency personnel.

Interviews for additional nursing and care staff are also underway, with offers issued for several posts. Recruitment remains a priority topic at weekly governance meetings.

Activities staffing has been partially addressed with two Activities Coordinator commencing on 17 November 2025 and 01 December. A structured interim timetable remains in place until full activities staffing is achieved, utilising services provided by local sources.
The PIC is actively overseeing daily staffing allocation to ensure residents with higher support needs are prioritised and to minimise delays in toileting, mobility assistance,

showering and personal care. The provider acknowledges that full elimination of delays will depend on achieving the full required staffing complement.

Residents who experienced delays in receiving showers or toileting assistance have been followed up with. Staff have been reminded to communicate clearly with residents if delays occur and to support residents as soon as possible. The PIC has increased morning oversight to ensure personal care routines are completed in line with residents' preferences.

The call-bell system has been approved for a full upgrade. The upgraded system will allow live reporting and monitoring of call-bell response times, improving oversight and enabling timely escalation of delays. Installation is planned as part of the wider infrastructure improvement programme and anticipated to be completed by the middle of December.

Weekly governance meetings now include formal reviews of staffing levels, recruitment progress and agency consistency. These oversight measures will continue until the centre has achieved a stable, compliant and sustainable staffing model.

The registered provider representative will continue to monitor staffing, care delivery and response times to ensure sustained progress toward full compliance.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A full audit of staff training records has been completed. Eight staff who required safeguarding, managing behaviours that challenge, fire safety and infection prevention and control training have completed training sessions.

The provider has engaged an external trainer to deliver bite-sized, on-the-floor training sessions to support day-to-day practice and reduce the need to pull staff away from resident care for classroom-style education. This approach allows training to be completed on the spot while observing real practice. A total of six training days have been booked for November and December, and the first session was completed on 17 November.

All staff have now received and completed Manual Handling Training.

To strengthen supervision, the PIC is currently providing increased oversight on the floor each day to monitor staff practice, provide corrective guidance where required, and ensure that all staff are implementing local policies and procedures. In addition to the PIC oversight, the provider has engaged external clinical support, with two senior clinical

staff supporting the PIC and providing coverage between them five days a week.

Poor practices identified during the inspection in relation to infection prevention and control—particularly in relation to the management of scabies, hand hygiene and PPE use—have been addressed directly with staff through immediate feedback and follow-up supervision. Staff have been reminded of the requirement to adhere strictly to IPC protocols at all times and non-compliance identified will result in immediate corrective action and supervision.

Improper medication storage, administration and stock-control practices observed during inspection have been addressed with the nursing team, and additional medicines-management oversight is being provided by the PIC.

Monthly medication audits, including stock control, storage checks and administration-record reviews, are now being completed. Any variances are followed up promptly with the staff involved.

The use of personal mobile phones while supporting residents has been addressed through direct instruction to staff, a re-affirmation of existing policy and the introduction of unannounced observation checks. Staff have been reminded that personal phones must not be used in resident areas and may only be accessed during designated break times in appropriate staff areas. The PIC will continue to monitor compliance with this through daily supervision, and any breaches will be escalated through the disciplinary process as required

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider acknowledges the concerns identified during the inspection and has taken immediate steps to address the risks and deficiencies highlighted. External clinical support has been contracted to assist the PIC with daily operational oversight and regulatory compliance.

In addition, a new Governance, Risk, and Compliance Officer commenced in the role on November 17th. She is enhancing the existing systems and processes within the Centre and strengthening overall governance and regulatory compliance.
A new Governance and Management (G&M) meeting structure has also been established, with the full support team attending onsite monthly to review key clinical KPIs and regulatory compliance. Alongside this, weekly onsite meetings are being conducted to monitor progress, staffing updates, and any additional issues raised by the PIC.
These measures will remain in place until the Centre achieves full regulatory compliance.

Emergency issues relating to epilepsy medication availability and medication storage were rectified on the day of inspection.

In addition, the provider has implemented a comprehensive programme of improvements across the areas identified under Regulations 17, 23, 27 and 29. Full details of these actions are outlined in the relevant sections of this compliance plan and should be read in conjunction with this summary.

In relation to resourcing, the provider acknowledges that the centre was not adequately resourced at the time of inspection. Several corrective actions are now underway. Short-term staff absences are now being escalated and efforts to source cover are documented. Eight HCAs are due to commence employment shortly, recruitment for additional nursing and activities staff is ongoing, and the centre has secured consistent agency staffing for the next three months. The provider has also engaged external clinical support, with two senior clinical staff supporting the PIC and providing coverage between them five days a week.

Additional linen and bed sheets have been ordered and fully restocked.

Communal rooms have been refurnished to ensure that residents have access to comfortable and appropriate spaces at all times.

Management systems in the centre have been strengthened significantly following the inspection. The provider acknowledges that the investigation of a serious incident was not sufficient, and has therefore commissioned an external, independent investigator to complete a full review. Learning and any required actions will be implemented and monitored through the governance process.

Maintenance and premises oversight have been escalated. Heating issues have been raised to the provider level, with remedial works planned. Interim measures, including portable heaters and temperature monitoring, are in place. Maintenance reporting pathways have been clarified and communicated to staff to ensure timely escalation of faults.

Systems for oversight of care planning, documentation, and care delivery have been strengthened. Gaps in assessments, care plans and records are being corrected as outlined under Regulation 5. Daily and weekly audits, direct supervision by the PIC, and clearer documentation processes have now been implemented to improve reliability and consistency.

Oversight of staff practice has been improved. The PIC is present on the floor daily to monitor compliance with policies relating to infection control, medication management, mobile phone use, complaints handling and documentation standards. Additional bite-sized training sessions are now being delivered on the floor by an external trainer, with six days booked for November and December, and the first session completed on 17 November.

Cleaning, infection prevention and stock management systems have been strengthened as outlined in detail under Regulation 27. This includes reorganising storage areas,

reinstating appropriate sluice arrangements, improving outbreak documentation, enhancing cleaning schedules and ensuring correct PPE, hand hygiene and decontamination practices.

Incident management and notifications have been reviewed. Any missed notifications have now been submitted and a strengthened notification system is in place, as outlined under Regulation 31. The PIC will ensure all future incidents are fully investigated with documented findings, learning and actions.

Audit systems have been reviewed and enhanced. Audits will now be completed consistently, findings acted upon, and outcomes monitored through the Quality & Safety governance structure. This includes improved medication audits, IPC audits, care plan audits and environment checks.

Information governance systems have been strengthened. Records are now centrally organised, stored securely and readily accessible for inspection. Staff have been reminded of documentation standards and the importance of timely, accurate record-keeping.
The provider acknowledges the breach of the registration condition identified in relation to the removal of the sluice facility in Kilminan wing. This room has now been reinstated for its intended purpose and the provider has put in place a formal process to ensure any future environmental changes are communicated to the Chief Inspector prior to implementation.

A detailed outline of the corrective and preventive actions for each specific regulatory area is provided under the relevant regulation within this compliance plan. These individual sections should be referred to for a full update on the actions being taken and the timelines for completion

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
From October 28th, the newly appointed PIC will ensure all serious incidents will be cross-checked against HIQA notification records and notifications will be submitted within the required regulatory timeframes.

Any previously unidentified notifiable incidents will be submitted to HIQA immediately upon identification, in line with Regulation 31.

The PIC will ensure all new notifications will be fully investigated, with findings, contributing factors, and required actions documented by the PIC.

Learning arising from incident reviews and notifications will be shared with staff through

several structured communication channels, including:
• Morning handovers
• Daily or weekly huddles
• One-to-one feedback where relevant
• Staff meetings (with standing agenda item for quality, safety, and incident learning)

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Registered Provider acknowledges the deficits identified in the management of complaints. Immediate actions have been taken to ensure that all complaints are now managed in line with the centre's complaints policy and the regulatory requirements.

Where a complaint cannot be resolved within 30 days, the complainant will now receive a documented update outlining the reason for the delay and when they can expect a full response.

A full review of all complaints records has been completed to ensure accuracy and completeness. Any gaps in historic documentation are being addressed, and all current and future complaints will be recorded in a centralised log with clear details of the issue, actions taken, learning identified and the outcome.

Residents and families have been reminded of the complaints process. Information on how to make a complaint is now clearly displayed throughout the centre, and residents have been informed directly through conversations and resident meetings.

Staff have also been reminded that all concerns raised by residents or families must be logged as complaints where appropriate, in line with the policy.

The PIC will review complaints weekly to ensure they are progressing appropriately, with monthly audits carried out as part of the Quality and Safety review.

The Registered Provider Representative will maintain oversight to ensure sustained compliance with the complaints process and to promote a culture where concerns are welcomed, recorded and used to inform improvements in the centre.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: A full review of personal property storage has been completed to ensure that all residents can access their belongings independently or with staff support, in line with their rights and preferences. Appropriate shelving, labelled storage boxes and wardrobe space have been organised to ensure personal property is stored safely, respectfully and in an accessible manner.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Registered Provider has commenced a full review of the physical environment to ensure it is safe, suitable, comfortable and fully aligned with the Statement of Purpose. Immediate actions have been taken to restore access to communal spaces and to improve the overall functioning and presentation of the centre. Staff have been instructed that resident communal spaces must not be used for staff breaks under any circumstances. All staff breaks now take place in the designated staff facility, and the PIC is monitoring compliance through daily walk-arounds. Staff have also been instructed that resident living rooms may not be used for meetings or interviews. Works being completed in the oratory and relaxation/aromatherapy rooms on the days of Inspection have now been completed and these have now been reopened and are available for resident use throughout the day. The sluice room on Kilminan wing has been cleared of all inappropriate storage and reinstated for its intended purpose. All unnecessary items have been removed and correct layout and usage have been restored. Repairs to damaged flooring in the staff room, smoking room and bedroom areas have been reviewed by an external contractor and pending quotations, works will be scheduled for completion. A system for monitoring, adjusting and recording temperatures throughout the centre has now been established. Thermometers have been installed in all key areas and temperatures are recorded at scheduled intervals. Heating issues identified in specific units have been escalated to the Provider, and remedial works are planned to ensure consistent and appropriate ambient temperatures throughout the centre. Residents and families who had raised concerns have been updated on the actions being taken. As an interim measure, portable heaters have been placed in bedrooms and communal areas to	

maintain comfort while permanent works are being completed.

Hot water temperatures in the visitors' toilet and residents' en-suite areas are scheduled to be adjusted as part of the ongoing heating and plumbing upgrade works. In the interim, appropriate warning signage has been put in place in these areas to alert residents, visitors and staff to the risk of hot water.

Communal rooms are being refurnished to ensure they are homely, comfortable and appropriately equipped. Additional seating has been ordered and delivered for the visitors' room and sitting rooms. Furnishings are being redistributed to ensure no communal rooms are left without appropriate furniture. The PIC is monitoring this daily to ensure rooms remain properly set up.

Residents who smoke are now being redirected to designated smoking areas only. Clear signage has been installed, and staff are supporting residents to use these areas to prevent smoking in doorways and corridors. Smoke detectors have also been repositioned and added as required to support compliance with this and to ensure safety is maintained.

All bedpan washers have been assessed and repairs completed.

Store rooms have been decluttered and reorganised to ensure correct segregation of equipment in line with infection-prevention standards.

A hand wash facility has been ordered and will be installed in the housekeeping room.

All equipment used by residents has been reviewed to ensure it is in working order. The television that was not functioning has been replaced. Regular equipment checks are now scheduled weekly to ensure uninterrupted access to functioning amenities.

The Registered Provider Representative will review progress monthly through governance meetings and ensure all actions remain on schedule and fully implemented.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A hand-wash basin has been ordered and will be installed in the housekeeping room to ensure housekeeping staff can perform hand hygiene at the point of use.

All clinical waste bins in the centre have been replaced with enclosed, pedal-operated bins in line with best-practice guidance.

Clothing belonging to residents that had been stored on the floor in the laundry or in an

upstairs storeroom has been removed and correctly stored. New storage systems have been implemented to ensure all textiles are elevated off the floor and segregated to prevent contamination. Staff have been reminded that clothing or linen may never be placed on floors or carpeted areas.

Used mops and cleaning cloths are no longer washed in domestic washing machine and this has been removed after the inspection.

All store rooms have been reorganised to ensure proper separation of items and to prevent cross-contamination. Mattresses, hoist slings, PPE and decorations have been relocated and stored appropriately, with all items lifted off the floor on suitable shelving. Store rooms will be checked weekly by the maintenance staff to ensure continued compliance with IPC standards.

Room disinfection processes have been revised to ensure that rooms are cleaned thoroughly prior to the application of disinfectant. Cleaning staff have been instructed on the correct sequence—clean first, disinfect second—and the PIC will carry out spot checks to ensure this is followed consistently.

Poor hand hygiene practices observed during inspection have been addressed through direct staff feedback, immediate corrective instruction and ongoing supervision by the new PIC.

Deep cleaning schedules have now been developed and implemented. Each room has a planned deep clean at regular intervals, and the completion of these cleans is recorded and monitored by the Head Housekeeper. Any missed or incomplete deep cleans will be addressed immediately.

Outbreak documentation has been updated to ensure clarity and accuracy. Line lists have been reformatted to be easy to follow, and staff completing outbreak records have been instructed on correct date entry, sequencing and documentation. The PIC will review outbreak documentation when in use to ensure accuracy.

PPE stations that remained in place despite scabies treatment being completed have now been removed. Staff have been instructed on current guidance regarding PPE usage to ensure PPE is used appropriately and aligns with evidence-based IPC practice.

A damaged mattress that had been taped has been removed and replaced. All mattresses have since been inspected, and any that do not meet infection control standards have been identified for replacement. Ongoing monthly mattress checks have now been introduced.

The PIC will continue to oversee IPC practices daily, supported by regular audits and governance oversight. Improvement actions will be monitored through the Quality & Safety Tracker, with the Registered Provider Representative reviewing progress monthly to ensure sustained compliance with national IPC standards.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The registered provider acknowledges the medication management deficits identified during inspection.

Immediate corrective actions were taken, and a full review of all medication storage, administration, documentation and governance practices has commenced under the oversight of the PIC.

All inappropriate storage of medication was immediately rectified. Prescribed topical products were removed from bathrooms and secured appropriately, and food supplements were removed from unlocked presses and stored safely.

Staff have been reminded in safety pauses and staff meetings that medications and supplements must never be left in communal or unsecured areas. Frequent environmental checks are now being completed by the new PIC to ensure safe storage practices are consistently followed.

All medicines that were no longer required have now been segregated, logged and arranged for disposal in line with national legislation and organisational policies. The practice of leaving discontinued medication unsecured has ceased. A designated area for the secure storage of discontinued medication awaiting pharmacy collection has been established, and this process will be monitored by the PIC.

Out-of-date medication found in the controlled drug press was removed immediately and In-date medication was obtained for the resident.

A full audit of all controlled drugs across the centre has since been completed to ensure no other expired medication is present. Expiry date checks are now being carried out daily by assigned nursing staff and verified weekly by the PIC.

Medication prescribed for the treatment of scabies will now be administered strictly in accordance with the prescriber’s directions. Nursing staff have reviewed all instructions for this medication and updated resident care documentation to reflect accurate timing, dosage and application requirements.

Medication administration records, including those for eye drops and scabies treatment, have been reviewed and corrected where inaccuracies were found. Nursing staff have been reminded of the requirement for complete, accurate, contemporaneous documentation for every medication administered or withheld. The Pharmacy will continue to audit medication administration records monthly until full compliance is achieved.

Issues identified in relation to the counting and management of controlled drugs have been addressed. All nurses have been reminded that controlled drugs must be checked and signed by two authorised staff, with clear documentation in the controlled drug register. The PIC is supervising controlled drug checks daily and monitoring adherence to best practice procedures.

A full medicines management audit has been completed, with additional pharmacy monthly audits scheduled until sustained compliance is demonstrated. Any issues identified during these audits will be addressed immediately.

The Registered Provider Representative will continue oversight through monthly governance reviews to ensure safe medication practices are consistently applied and maintained.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The registered provider acknowledges the issues identified in relation to assessment and care planning. A full review of all residents' assessments and care plans has commenced to ensure that each resident's needs are accurately assessed, clearly documented and reflected in person-centred care plans that guide staff effectively. This review is being led by the PIC with oversight from the Clinical Governance Team.

All assessments found to be incomplete, inaccurate or inconsistent are in process of rechecked, corrected and updated. This includes dietary, mobility, manual handling, personal care and risk assessments. Where discrepancies are identified between assessments, care plans and progress notes, these are being aligned immediately to ensure consistency in care direction. For example, in the case of the resident with lactose intolerance, the care plan has been corrected to accurately reflect dietary requirements and this process is being applied to all other care plans where errors were found.

Care plans are being rewritten where needed to ensure they are specific, individualised and person-centred, rather than generic or pre-populated. Each plan will include clear, resident-focused interventions, preferences and instructions that support staff to deliver care in line with assessed needs. All updated care plans will be reviewed and signed by the PIC or senior nurse prior to final approval.

Where discrepancies in mobility or manual handling guidance were identified, these are being corrected so that each care plan contains clear and consistent instructions. The PIC is reviewing all mobility and manual handling plans with staff to ensure correct equipment use and staffing levels are understood and applied in practice. Any conflicting information is being removed and replaced with accurate MDT-supported guidance.

The PIC is also monitoring daily care delivery on the floor to ensure residents' personal needs, preferences and routines are being met.

Staffing levels and allocation have been reviewed to ensure residents receive timely support with rising, dressing and personal care. Any gaps in meeting residents' needs are escalated through the PIC and addressed immediately with the care team.

Weekly audits of care plans will continue until all plans have been fully reviewed and updated, followed by monthly audits thereafter.

Any gaps in information, MDT direction or staff understanding will be escalated and resolved promptly.

Governance oversight will be maintained through monthly governance meetings to ensure sustained compliance with assessment and care planning requirements.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All residents with epilepsy or a history of seizures are being reviewed to ensure they have an individualised epilepsy protocol in place. These protocols will include seizure history, known triggers, clear guidance for staff on recognising and responding to seizures, medication and rescue medication instructions, and escalation procedures.

MDT input is being sought where needed to confirm clinical directions. Updated protocols will be signed, dated, accessible in care plans and communicated to staff. The PIC will audit care plans monthly to ensure they remain current.

The PIC has reviewed all residents with current or previous fractures to ensure clear clinical guidance is documented regarding healing status, mobility restrictions, supports required and any rehabilitation needs.

GP and MDT follow-up has been requested where further clarification is required. Updated clinical instructions will be added to care plans and communicated to staff to ensure consistent management.

Residents identified as being at high risk of fractures are being reassessed and this risk is now being formally documented in their care plans, and mobility profiles. MDT professionals including a new GP Service are providing guidance on risk-reduction measures, equipment or mobility aids, any required supervision levels. These recommendations are being incorporated into care plans and communicated to staff at handover.

The PIC will carry out weekly reviews until all healthcare plans are updated, followed by monthly audits. Any gaps in clinical information or MDT direction will be escalated immediately to the relevant clinicians.

A schedule of GP review meetings is in place to ensure residents' healthcare needs and clinical instructions remain accurate and up to date.

The Registered Provider Representative will monitor progress through monthly governance meetings to ensure sustained compliance.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Registered Provider acknowledges that the investigation undertaken at the time of the incident did not meet the required standard of a comprehensive safeguarding investigation. To address this, the provider has now engaged the services of an external, independent contractor to complete a full investigation into the incident.

This investigation will examine all aspects of the event, including any potential misconduct, safeguarding concerns, staff practices and systemic contributing factors.

Findings, recommendations and required corrective actions from the independent investigation will be submitted to the Registered Provider upon completion and shared with the Person in Charge (PIC). These findings will inform improvements in local practice, supervision, reporting and safeguarding procedures.

The new PIC will ensure that all incidents meeting the criteria for safeguarding review or alleged misconduct will, going forward, receive a comprehensive and fully documented investigation in line with national and organisational safeguarding policies.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All communal rooms—including the two day rooms, conservatory, oratory and relaxation rooms—have now been reopened and are fully accessible to residents throughout the day. Staff have been instructed to actively encourage and support residents to utilise these communal spaces for social interaction, activities and relaxation. The PIC will monitor this each day.
One parttime Activities Coordinator is commenced on 17 November 2025, and one other

Activities staff are due to commence 01st December. When in post, these roles will provide consistent, seven-day activity coverage, including weekend support and relief cover. This enhanced staffing will ensure structured group sessions, meaningful 1:1 engagement and sensory-based activities are available daily.
Records of all activity provision—including resident participation, level of engagement, refusals, alternatives offered and all 1:1 sessions—will be updated daily. The increase in activity staffing ensures adequate time and capacity to maintain accurate, person-centred activity records. The PIC will review documentation weekly, and any gaps or omissions will be highlighted to the Activities Team. Activity provision will also be monitored as part of the monthly Compliance Audit.
The activity schedule is being fully reviewed and updated, with direct input from residents through resident meetings, satisfaction surveys and individual discussions. The revised schedule will be displayed clearly in all communal areas and refreshed weekly to ensure accuracy. This process will be overseen and signed off by the Activities Coordinator to ensure the schedule always reflects the activities actually delivered.
With the introduction of additional Activities Staff, a structured 1:1 activity programme will be in place for residents who remain in their bedrooms or who require enhanced individual support. Activity Staff will have designated periods each day to provide engagement such as sensory stimulation, reminiscence, reading, music, conversation and personalised therapeutic activities. All 1:1 engagement will be recorded daily and reviewed by the PIC for quality and consistency.
Morning routines and staffing allocations have been reviewed to ensure residents can exercise choice regarding when they get up, rest or receive assistance. The PIC is currently focused on the day-to-day running of the floor and is actively overseeing morning routines to ensure residents' preferences are respected. Any delays or issues identified are followed up promptly by the PIC.
Resident preferences and feedback are actively informing enhancements to the activities programme. Activities that residents have requested are being implemented, including:
• Re-established flower arranging workshops
• A new beauty therapy morning
• Additional music and singing sessions
• Increased involvement of local community and activity providers
These additions will broaden meaningful options and ensure residents can choose from activities that reflect their interests.
The PIC conducts daily oversight of activity provision and resident engagement. Activity outcomes, participation levels and feedback will be reviewed at monthly Governance and Management Meetings.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	19/11/2025
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	20/01/2026
Regulation 16(1)(a)	The person in charge shall	Not Compliant	Orange	15/12/2025

	ensure that staff have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	19/11/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	18/11/2025
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.	Not Compliant	Orange	15/11/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	20/01/2026
Regulation 23(1)(d)	The registered provider shall	Not Compliant	Orange	30/12/2025

	ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and 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.	Not Compliant	Orange	28/11/2025
Regulation 27(c)	The registered provider shall ensure that staff receive suitable training on infection prevention and control.	Not Compliant	Orange	20/11/2025
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	19/11/2025
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident	Not Compliant	Orange	19/11/2025

	concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	19/11/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within	Not Compliant	Orange	20/11/2025

	2 working days of its occurrence.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	30/12/2025
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Not Compliant	Orange	30/12/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/10/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared	Not Compliant	Orange	15/01/2026

	under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	15/01/2026
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	30/11/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to	Not Compliant	Orange	30/10/2025

	protect residents from abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/10/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	30/11/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	15/12/2025
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	Orange	15/12/2025